

REPORT OF MEDICAL EXAMINATION	1. DATE OF EXAMINATION (YYYYMMDD)	2. SOCIAL SECURITY NUMBER
--------------------------------------	--------------------------------------	---------------------------

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code)	5. HOME TELEPHONE NUMBER (Include Area Code)
---	--	---

6. GRADE	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	10.a. RACIAL CATEGORY (X one or more) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Decline to Respond	b. ETHNIC CATEGORY <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Decline to Respond
----------	--------------------------------	--------	--	---	---

11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY	b. CIVILIAN	12. AGENCY (Non-Service Members Only)	13. ORGANIZATION UNIT AND UIC/CODE
---	-------------	---------------------------------------	------------------------------------

14.a. RATING OR SPECIALTY (Aviators Only)	b. TOTAL FLYING TIME	c. LAST SIX MONTHS
---	----------------------	--------------------

15.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	c. PURPOSE OF EXAMINATION <input type="checkbox"/> Medical Board <input type="checkbox"/> other <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <input type="checkbox"/> Retention <input type="checkbox"/> Submarine Duty <input type="checkbox"/> Separation <input type="checkbox"/> Diving Duty	16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include ZIP Code)
---	---	--	---

CLINICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.)

	Nor- mal	Ab- norm	NE	44. NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)
17. Head, face, neck, and scalp				
18. Nose				
19. Sinuses				
20. Mouth and throat				
21. Ears - General (Int. and ext. canals/Auditory acuity under item 71)				
22. Drums (Perforation)				
23. Eyes - General (Visual acuity and refraction under items 61 - 63)				
24. Ophthalmoscopic				
25. Pupils (Equality and reaction)				
26. Ocular motility (Associated parallel movements, nystagmus)				
27. Heart (Thrust, size, rhythm, sounds)				
28. Lungs and chest (Include breasts)				
29. Vascular system (Varicosities, etc.)				
30. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)				
31. Abdomen and viscera (Include hernia)				
32. External genitalia (Genitourinary)				
33. Upper extremities				
34. Lower extremities (Except feet)				
35. Feet (See Item 35 Continued)				
36. Spine, other musculoskeletal				
37. Identifying body marks, scars, tattoos				
38. Skin, lymphatics				
39. Neurologic				
40. Psychiatric (Specify any personality deviation)				
41. Pelvic (Females only)				
42. Endocrine				

43. DENTAL DEFECTS AND DISEASE (Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in Item 44.) <input type="checkbox"/> Acceptable <input type="checkbox"/> Not Acceptable Class _____	35. FEET (Continued) (Circle category) Normal Arch Mild Asymptomatic Pes Cavus Moderate Pes Planus Severe Symptomatic
---	---

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
---	------------------------

LABORATORY FINDINGS				
45. URINALYSIS	a. Albumin	46. URINE HCG	47. WBC/HCT/PLT	48. BLOOD TYPE
	b. Sugar			
TESTS	RESULTS	HIV SPECIMEN ID LABEL		DRUG TEST SPECIMEN ID LABEL
50. DRUGS				
51. ALCOHOL				
52. OTHER				
a.				
b.				
c.				

MEASUREMENTS AND OTHER FINDINGS																	
53. HEIGHT	54. WEIGHT lbs.	55. MIN WGT - MAX WGT MAX BF %			56. TEMPERATURE	57. PULSE											
58. BLOOD PRESSURE			59. RED/GREEN (<i>Army Only</i>)			60. OTHER VISION TEST											
a. 1ST	b. 2ND	c. 3RD															
SYS.	SYS.	SYS.															
DIAS.	DIAS.	DIAS.															
61. DISTANT VISION			62. REFRACTION BY AUTOREFRACTION OR MANIFEST			63. NEAR VISION											
Right 20/	Corr. to 20/	By	S.	CX	Right 20/	Corr. to 20/	by										
Left 20/	Corr. to 20/	By	S.	CX	Left 20/	Corr. to 20/	by										
64. HETEROPHORIA (<i>Specify distance</i>)																	
ES ^o	EX ^o	R.H.	L.H.	Prism div.	Prism Conv CT	NPR	PD										
65. ACCOMMODATION			66. COLOR VISION (<i>Test used and result</i>)			67. DEPTH PERCEPTION (<i>Test used and score</i>) AFVT											
Right	Left	PIP /14			Uncorrected	Corrected											
68. FIELD OF VISION				69. NIGHT VISION (<i>Test used and score</i>)				70. INTRAOCULAR TENSION									
								O.D.	O.S.								
71a. AUDIOMETER		Unit Serial Number					71b. Unit Serial Number					72a. READING ALOUD TEST					
Date Calibrated (YYYYMMDD)							Date Calibrated (YYYYMMDD)										
HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000	<input type="checkbox"/>	SAT	<input type="checkbox"/>	UNSAT
Right							Right							72b. VALSALVA			
Left							Left							<input type="checkbox"/>	SAT	<input type="checkbox"/>	UNSAT

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY (*Use additional sheets if necessary.*)

REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

*Form Approved
OMB No. 0704-0413
Expires Oct 31, 2006*

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0413). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397 (SSAN).

PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE (YYYYMMDD)
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)	
b. HOME TELEPHONE (Include Area Code)		

X ALL APPLICABLE BOXES:			7.a. POSITION (Title, Grade, Component)
6.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	6.b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	6.c. PURPOSE OF EXAMINATION <input type="checkbox"/> Medical Board <input type="checkbox"/> Other <input type="checkbox"/> Retirement <input type="checkbox"/> Submarine Duty <input type="checkbox"/> Diving Duty <input type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation	b. USUAL OCCUPATION

8. CURRENT MEDICATIONS (Prescription and Over-the-counter)	9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)
--	--

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	12. (Continued)	YES	NO
10.a. Tuberculosis	<input type="radio"/>	<input type="radio"/>	f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input type="radio"/>	i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input type="radio"/>	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input type="radio"/>
f. Bronchitis	<input type="radio"/>	<input type="radio"/>	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="radio"/>	<input type="radio"/>
g. Wheezing or problems with wheezing	<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
h. Been prescribed or used an inhaler	<input type="radio"/>	<input type="radio"/>	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (cracked or fractured)	<input type="radio"/>	<input type="radio"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>	e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="radio"/>	<input type="radio"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>	c. Currently in good health (If no, explain in Item 29 on Page 2.)	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input type="radio"/>	d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input type="radio"/>

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
---	------------------------

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO		YES	NO	
15.a. Dizziness or fainting spells	<input type="radio"/>	<input type="radio"/>	19. Have you been refused employment or been unable to hold a job or stay in school because of:	<input type="radio"/>	<input type="radio"/>	
b. Frequent or severe headache	<input type="radio"/>	<input type="radio"/>		a. Sensitivity to chemicals, dust, sunlight, etc.	<input type="radio"/>	<input type="radio"/>
c. A head injury, memory loss or amnesia	<input type="radio"/>	<input type="radio"/>		b. Inability to perform certain motions	<input type="radio"/>	<input type="radio"/>
d. Paralysis	<input type="radio"/>	<input type="radio"/>		c. Inability to stand, sit, kneel, lie down, etc.	<input type="radio"/>	<input type="radio"/>
e. Seizures, convulsions, epilepsy or fits	<input type="radio"/>	<input type="radio"/>		d. Other medical reasons <i>(If yes, give reasons.)</i>	<input type="radio"/>	<input type="radio"/>
f. Car, train, sea, or air sickness	<input type="radio"/>	<input type="radio"/>		20. Have you ever been treated in an Emergency Room? <i>(If yes, for what?)</i>	<input type="radio"/>	<input type="radio"/>
g. A period of unconsciousness or concussion	<input type="radio"/>	<input type="radio"/>			21. Have you ever been a patient in any type of hospital? <i>(If yes, specify when, where, why, and name of doctor and complete address of hospital.)</i>	<input type="radio"/>
h. Meningitis, encephalitis, or other neurological problems	<input type="radio"/>	<input type="radio"/>		22. Have you ever had, or have you been advised to have any operations or surgery? <i>(If yes, describe and give age at which occurred.)</i>	<input type="radio"/>	<input type="radio"/>
16.a. Rheumatic fever	<input type="radio"/>	<input type="radio"/>	23. Have you ever had any illness or injury other than those already noted? <i>(If yes, specify when, where, and give details.)</i>		<input type="radio"/>	<input type="radio"/>
b. Prolonged bleeding <i>(as after an injury or tooth extraction, etc.)</i>	<input type="radio"/>	<input type="radio"/>	24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? <i>(If yes, give complete address of doctor, hospital, clinic, and details.)</i>	<input type="radio"/>	<input type="radio"/>	
c. Pain or pressure in the chest	<input type="radio"/>	<input type="radio"/>		25. Have you ever been rejected for military service for any reason? <i>(If yes, give date and reason for rejection.)</i>	<input type="radio"/>	<input type="radio"/>
d. Palpitation, pounding heart or abnormal heartbeat	<input type="radio"/>	<input type="radio"/>	26. Have you ever been discharged from military service for any reason? <i>(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)</i>	<input type="radio"/>	<input type="radio"/>	
e. Heart trouble or murmur	<input type="radio"/>	<input type="radio"/>		27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? <i>(If yes, specify what kind, granted by whom, and what amount, when, why.)</i>	<input type="radio"/>	<input type="radio"/>
f. High or low blood pressure	<input type="radio"/>	<input type="radio"/>	28. Have you ever been denied life insurance?	<input type="radio"/>	<input type="radio"/>	
17.a. Nervous trouble of any sort <i>(anxiety or panic attacks)</i>	<input type="radio"/>	<input type="radio"/>		29. EXPLANATION OF "YES" ANSWER(S) <i>(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)</i>		
b. Habitual stammering or stuttering	<input type="radio"/>	<input type="radio"/>				
c. Loss of memory or amnesia, or neurological symptoms	<input type="radio"/>	<input type="radio"/>				
d. Frequent trouble sleeping	<input type="radio"/>	<input type="radio"/>				
e. Received counseling of any type	<input type="radio"/>	<input type="radio"/>				
f. Depression or excessive worry	<input type="radio"/>	<input type="radio"/>				
g. Been evaluated or treated for a mental condition	<input type="radio"/>	<input type="radio"/>				
h. Attempted suicide	<input type="radio"/>	<input type="radio"/>				
i. Used illegal drugs or abused prescription drugs	<input type="radio"/>	<input type="radio"/>				
18. FEMALES ONLY. Have you ever had or do you now have:						
a. Treatment for a gynecological (female) disorder	<input type="radio"/>	<input type="radio"/>				
b. A change of menstrual pattern	<input type="radio"/>	<input type="radio"/>				
c. Any abnormal PAP smears	<input type="radio"/>	<input type="radio"/>				
d. First day of last menstrual period <i>(YYYYMMDD)</i>						
e. Date of last PAP smear <i>(YYYYMMDD)</i>						

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION <i>(Sign each entry)</i>
/ /	SEPARATION FROM ACTIVE DUTY
	Reference: Manual of the Medical Department P-117 (15-29)
BP:	
Temp:	(1) Dental exam current or dental stamp on SF 88 stating dental work complete or
Pulse:	Not complete within 180 days of separation: ()
Resp:	
	Article 15-29
	(2) You have been evaluated because of your planned separation or retirement from active duty service. You have been found physically qualified to separate or retire, which means that no medical condition has been noted that disqualifies you from the performance of your duties or warrants disability evaluation system processing. To receive disability benefits from the Department of the Navy, you must be unfit to perform the duties of your office, grade, or rating because of a disease or injury incurred or exacerbated while in receipt of base pay. Some conditions, while not considered disqualifying for separation or retirement, may entitle you to benefits from the Department of Veteran's Affairs. If you desire additional information regarding these benefits, contact the Department of Veteran's Affairs at 1-800-827-1000 or view the web site at: http://www.va.gov
	Member's Signature:
	(3) Current HIV date:
	(4) Does member want to be tested for Hepatitis C: () Yes (x) No
	* If yes, patient sign here _____ . (35 years of age and older)
	(5) Date of Last Physical Examination:
	(6) Review of Medical History (include Physicals, Immunizations, and SF 600's)
	(7) Any Interval Changes since Last Physical Exam:
	Member is physically qualified / Not physically qualified for separation from USN.
Patient's Identification (Use this space for Mechanical Imprint)	
Records Maintained At: ►	
Patient's Name (Last, First, MI)	
Sex	
Relationship to Sponsor	Status
SELF	AD
Sponsor's Name	
SELF	
Organization	
USN	
Depart./Service	SSN/Identification No.
USN	20/
Date of Birth	

REPORT OF MEDICAL ASSESSMENT

REPORT CONTROL SYMBOL

PRIVACY ACT STATEMENT

AUTHORITY: PL 103-160, EO 9397.

PRINCIPAL PURPOSE: To be used by the Medical Services to provide a comprehensive medical assessment for active and reserve component service members separating or retiring from active duty.

ROUTINE USES: A copy of this form will be released to the Department of Veterans Affairs.

DISCLOSURE: Voluntary; however, failure to disclose the requested personal information may result in delay in processing any disability claim.

SECTION I - TO BE COMPLETED BY SERVICE MEMBER. Any service member who requests a physical examination may have one.

1. NAME <i>(Last, First, Middle)</i>	2. SOCIAL SECURITY NUMBER	3. RANK
--------------------------------------	---------------------------	---------

4. COMPONENT	5. UNIT OF ASSIGNMENT
--------------	-----------------------

6a. HOME STREET ADDRESS <i>(Or RFD, including apartment number)</i>	b. CITY	c. STATE	d. ZIP CODE	7. HOME TELEPHONE NUMBER <i>(Include area code)</i>
---	---------	----------	-------------	---

8. DATE OF LAST PHYSICAL EXAMINATION BY THE MILITARY <i>(YYMMDD)</i>	9. DATE ENTERED ON CURRENT ACTIVE DUTY <i>(YYMMDD)</i>
--	--

10. COMPARED TO MY LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, MY OVERALL HEALTH IS *(X one. If "Worse," explain.)*

THE SAME

BETTER

WORSE

11. SINCE YOUR LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, HAVE YOU HAD ANY ILLNESSES OR INJURIES THAT CAUSED YOU TO MISS DUTY FOR LONGER THAN 3 DAYS? *(X one. If "Yes," explain.)*

NO

YES

12. SINCE YOUR LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, HAVE YOU BEEN SEEN BY OR BEEN TREATED BY A HEALTH CARE PROVIDER, ADMITTED TO A HOSPITAL, OR HAD SURGERY? *(X one. If "Yes," explain.)*

NO

YES

13. HAVE YOU SUFFERED FROM ANY INJURY OR ILLNESS WHILE ON ACTIVE DUTY FOR WHICH YOU DID NOT SEEK MEDICAL CARE? *(X one. If "Yes," explain.)*

NO

YES

14. ARE YOU NOW TAKING ANY MEDICATIONS? *(X one. If "Yes," list medications.)*

NO

YES

15. DO YOU HAVE ANY CONDITIONS WHICH CURRENTLY LIMIT YOUR ABILITY TO WORK IN YOUR PRIMARY MILITARY SPECIALTY OR REQUIRE GEOGRAPHIC OR ASSIGNMENT LIMITATIONS? *(X one. If "Yes," explain.)*

NO

YES

16. DO YOU HAVE ANY DENTAL PROBLEMS? *(X one. If "Yes," explain.)*

NO

YES

17. DO YOU HAVE ANY OTHER QUESTIONS OR CONCERN ABOUT YOUR HEALTH? *(X one. If "Yes," explain.)*

NO

YES

18. AT THE PRESENT TIME, DO YOU INTEND TO SEEK DEPARTMENT OF VETERANS AFFAIRS (VA) DISABILITY? *(X one. If "Yes," list conditions for which you will ask for VA Disability.)*

NO

YES

UNCERTAIN

19. CERTIFICATION. I certify that the information provided above is true and complete to the best of my knowledge.

a. SIGNATURE OF SERVICE MEMBER	b. DATE SIGNED
--------------------------------	----------------

SECTION II - TO BE COMPLETED BY INDIVIDUALLY PRIVILEGED HEALTH CARE PROVIDER

This Report of Medical Assessment is to be used by the Medical Services to provide a comprehensive medical assessment for active and reserve component service members separating or retiring from active duty. The assessment will cover, as a minimum, the period since the service member's last medical assessment/physical examination, or the period of this call or order to active duty. Any service member who requests a physical examination may have one. Any service member who has indicated "yes" to Item 18 will have an appropriate physical examination, if the last examination is more than 12 months old and/or there are new signs and/or symptoms. If the service member answers "Worse" to Item 10 or "Yes" to Items 11, 12, or 14 through 18, documentation of the injury, illness, or problem should be included in the service member's medical or dental record.

20. HEALTH CARE PROVIDER COMMENTS *(All patient complaints must be addressed)***21. WAS PATIENT REFERRED FOR FURTHER EVALUATION?** *(X one. If "Yes," specify where.)*

- NO
 YES

22. PURPOSE OF ASSESSMENT *(X one. If "Other," explain.)*

- SEPARATION *(Includes discharge from military service and release from active duty, including release of National Guard and Reserve personnel voluntarily or involuntarily called or ordered to active duty.)*
 RETIREMENT
 OTHER

23. MEDICAL FACILITY**24. DATE OF ASSESSMENT**
*(YYMMDD)***25. HEALTH CARE PROVIDER**

- a. NAME *(Last, First, Middle Initial)* b. GRADE/RANK c. SIGNATURE

PHYSICAL EXAM ROUTING SHEET

NAME: _____

RANK/UNIT: _____

LASSN: _____

LOCATION; TODAY'S DATE: _____

1ST FLOOR JULIE HILL (CHCS/DMIS INPUT) _____

3RD FLOOR DENTAL: _____

BASEMENT LAB: _____

BASEMENT X-RAY: _____

BASEMENT INTERNAL MONITORING _____

1ST FLOOR AUDIO: _____

1ST FLOOR OPT: _____

1ST FLOOR VITAL SIGNS _____

1ST FLOOR EKG: _____

PREV MED _____

TYPE OF PHYSICAL _____

PART II DATE/TIME _____

PROVIDER _____

NOTES: _____

MEDICAL BOARD PATIENT QUESTIONNAIRE
Naval Health Clinic New England, Newport, RI

NAME: _____ RANK/RATE _____
 Last First Middle Initial

SSN _____ ETH ORIG _____ RACE _____ SEX _____ DOB _____

SERVICE _____ PEBD/ADSD _____ EAOS _____
(Pay Entry Base Date/Active Duty Service Date) (End of Active Service)

DESIG/MOS/JOB TITLE _____ PRD _____

LENGTH OF ACTIVE SERVICE _____ YEARS _____ MONTHS.

ARE YOU AN ACTIVE RESERVIST? _____ TAR? _____ DRILLING RESERVIST? _____

LENGTH OF RESERVE SERVICE (if applicable) _____ YEARS _____ MONTHS

DUTY STATION _____

DUTY ADDRESS _____ UIC/RUC _____

IMMEDIATE SUPERVISOR NAME/PHONE # _____

PHONE: HOME () _____ WORK () _____ DSN _____ CELL() _____

HOME ADDRESS _____

E-MAIL ADDRESS _____

PRIOR BOARDS _____
(List any Prior Boards, Dates and Diagnoses)

ARE YOU CURRENTLY PENDING ANY DISCIPLINARY ACTION OR AN INVOLUNTARY SEPARATION? YES _____ NO _____ INITIALS _____

WHAT WAS THE CAUSE OF YOUR MEDICAL PROBLEM? CHECK ONE:

_____ DISEASE	_____ ACCIDENTAL	_____ BATTLE CASUALTY
_____ ASSAULT	_____ FALL	_____ ATHLETICS/SPORTS
_____ MVA	_____ OTHER (SPECIFY) _____	

I hereby certify that the information given above is complete and accurate to the best of my knowledge. I understand that any changes to my PRD must be reported to Medical Board Staff.

PATIENT'S SIGNATURE _____ DATE _____

