



**SECTION II**

83. REMARKS. Every "yes" response in items 7 through 81 must be explained in the space provided. Give specific dates and details including names of physicians and hospitals or clinics and the current status of the condition. Continue on a separate sheet and attach to this form if additional space is needed.

84. CERTIFICATION. I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the physicians, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE

SIGNATURE

DATE SIGNED  
(YYYYMMDD)

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

85. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Examiner shall comment on all "Yes" and blank answers (indicating the item number before each comment). Develop by interview any additional medical history deemed important, and record significant findings here. If additional space is needed, continue on a separate sheet and attach to this form.)*

86. PHYSICIAN OR EXAMINER

TYPED OR PRINTED NAME

SIGNATURE

DATE SIGNED  
(YYYYMMDD)87. NUMBER OF  
ATTACHED  
SHEETS



**CLINICAL EVALUATION**

NORMAL	<i>(X each item in the appropriate column. Enter "NE" if not evaluated)</i>	ABNOR- MAL	NORMAL	<i>(X each item in the appropriate column. Enter "NE" if not evaluated)</i>	ABNOR- MAL
	30. HEAD, FACE, NECK AND SCALP			44. ABDOMEN AND VISCERA <i>(Include hernia)</i>	
	31. NOSE			45. ENDOCRINE SYSTEM	
	32. SINUSES			46. SPINE, OTHER MUSCULOSKELETAL	
	33. MOUTH AND THROAT			47. UPPER EXTREMITIES <i>(Strength, sensation, range of motion)</i>	
	34. EARS - GENERAL <i>(Internal and external canals) (Auditory acuity under item 14)</i>			48. LOWER EXTREMITIES <i>(Except feet) (Strength, sensation, range of motion)</i>	
	35. DRUMS <i>(Perforation)</i>			49. FEET	
	36. VALSALVA			50. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	37. EYES - GENERAL <i>(Visual acuity and refraction under items 18, 19, and 20)</i>			51. SKIN, LYMPHATICS	
	38. PUPILS <i>(Equality and reaction)</i>			52. GU SYSTEM	
	39. OCULAR MOTILITY <i>(Associated parallel movements, nystagmus)</i>			53. ANUS AND RECTUM <i>(Hemorrhoids, fistulae) (Prostate if indicated) EXTERNAL EXAM</i>	
	40. OPHTHALMOSCOPIC			54. FEMALE GU EXTERNAL VISUAL EXAM	
	41. LUNGS AND CHEST <i>(Include breasts)</i>			55. NEUROLOGIC	
	42. HEART <i>(Thrust, size, rhythm, and sounds)</i>			56. PSYCHIATRIC <i>(Specify any personality deviation)</i>	
	43. VASCULAR SYSTEM <i>(Varicosities, etc.)</i>				

57. REPEAT BP OR PULSE EXAM (SITTING) IF BP  $\geq$  140/90 OR PULSE  $\geq$  100

58. NOTES *(Describe every abnormality in detail. Enter the item number before each comment.)*

59. EXAMINER *(If performed by PA or PCNP)*

TYPED OR PRINTED NAME	RANK	CORPS OR DEGREE	SIGNATURE
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60. PHYSICIAN

TYPED OR PRINTED NAME	RANK	DEGREE	SIGNATURE
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**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
FARNSWORTH LANTERN AND  
RED/GREEN COLOR VISION TESTS**

OMB No. 0704-0396  
OMB approval expires  
Nov 30, 2009

The public reporting burden for this collection of information is estimated to average 20 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 Directorate, Information Management Division, 1155 Defense Pentagon, Washington, DC 20301-1155 (0704-0396). 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 TO DODMERB/DR, 8034 EDGERTON DRIVE, SUITE 132, USAF ACADEMY CO 80840-2200.**

**PRIVACY ACT STATEMENT**

**AUTHORITY:** Title 10, USC 133, 3012, 5031, 8013, and Executive Order 9397.

**PRINCIPAL PURPOSE:** To determine medical acceptability or update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Program, or the Uniformed Services University of the Health Sciences (USUHS).

**ROUTINE USES:** This information may be disclosed to the Coast Guard Academy and Merchant Marine Academy for applications to their Academies.

**DISCLOSURE:** Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy. Use of the Social Security Number (SSN) is used for positive identification of records.

1. NAME OF APPLICANT (*Last, First, Middle Initial*)

2. SOCIAL SECURITY NUMBER

**FARNSWORTH LANTERN**

**IMPORTANT: This test MUST be performed or verified and countersigned by an optometrist, flight surgeon, or by a physician experienced in performing the FALANT test.**

**INSTRUCTIONS TO EXAMINERS**

**READ REVERSE SIDE OF THIS FORM BEFORE ADMINISTERING TEST.** Indicate by letter the applicants' responses, reminding them at the beginning of the test that there are only three responses: Red, Green, or White.

	G/R	W/G	G/W	G/G	R/G	W/R	W/W	R/W	R/R	NUMBER OF ERRORS PER RUN
1st RUN										
2nd RUN										
3rd RUN										

**NOTES: Farnsworth Dichotomous or other variations are not acceptable.  
The examiner must alter the sequence of lights on the 2nd and 3rd runs.**

**RED/GREEN COLOR VISION TEST**

3. I CERTIFY THAT APPLICANT

CAN

CANNOT

DISTINGUISH AND IDENTIFY OBJECTS THAT ARE BRIGHT RED AND BRIGHT GREEN.

4. EXAMINER

NAME (*Last, First, Middle Initial*)

TITLE

EXAMINER SIGNATURE

DATE  
(YYYYMMDD)

PHYSICIAN SIGNATURE

DATE  
(YYYYMMDD)

5. FACILITY NAME AND COMPLETE

ADDRESS (*Street, City, State, ZIP Code*)

## FARNSWORTH LANTERN AND RED/GREEN COLOR VISION TESTS - INSTRUCTIONS

### PREPARATION FOR TESTING

1. Give the test in a normally lighted room; screen from glare; exclude sunlight. Examinee should not face the source of room illumination.
2. Only one person should be tested at a time. (Others shall not be allowed to watch.)
3. Station examinee eight feet from lantern.
4. If examinee ordinarily wears contact lenses or glasses for distance, they should be worn. Color correcting lenses, if worn, must be removed prior to testing.

### ADMINISTRATION AND SCORING

1. Instruct examinee, "The lights you will see in this lantern are either red, green, or white. They look like signal lights at a distance. Two lights are presented at a time - in any combination. Call out the colors as soon as you see them, naming first the color at the top and then the color at the bottom. Remember, only three colors - red, green, and white. Name which light color combination exists, top one first."
2. Turn knob at top of lantern to charge lights; depress button in center of knob to expose lights. Maintain regular timing of about two seconds per light.
3. Expose the lights in random order starting with a R/G or G/R combination, continuing until each of the nine combinations has been exposed.
4. If no errors are made on this first run of nine pairs of lights, examinee is passed.
5. If any errors are made on this first run, give two more complete runs.
6. Average the errors of these last two runs. If an average of more than one error per run is made, examinee is failed. If an average of one, or less than one error per run is made, examinee is passed.
7. An error is considered the miscalling of one or both of a pair of lights; if an examinee changes his/her response before the next light is presented, record the second response only.
8. If an examinee says "yellow," "pink," etc., you should say, "There are only three colors - red, green, and white."
9. If an examinee takes over 3 seconds to respond, you should say, "As soon as you see the lights, call them."
10. Do not discuss passing/failing scores with applicant. Under no circumstances will an applicant receive more than 3 total runs.

6. REMARKS *(Attach additional pages if necessary.)*

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
REPORT OF DENTAL EXAMINATION**

*Form Approved  
OMB No. 0704-0396  
Expires Aug 31, 2003*

The public reporting burden for this collection of information is estimated to average 20 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 Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0396), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be **PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM TO DODMERB/DR, 8034 EDGERTON DRIVE, SUITE 132, USAF ACADEMY CO 80840-2200.**

**PRIVACY ACT STATEMENT**

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<b>1. NAME OF APPLICANT</b> <i>(Last, First, Middle Initial)</i>	<b>2. SSN OF APPLICANT</b>
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**INSTRUCTIONS**

To be completed at scheduled Examining Center by the Examining Dentist. Panoramic and bitewing radiographs must accompany this examination and be identified by name and SSN. Expedite completed Dental Examination with completed Medical Examination to:

<p><b>3. INDICATE ON THE CHART BELOW, RESTORABLE, NON-RESTORABLE, MISSING TEETH, TEETH REPLACED, SPACES CLOSED AND ANY DEFECTS OR ABNORMALITIES.</b> <i>(Do not chart restorations.)</i></p>	<p><b>4. TYPED OR PRINTED NAME OF EXAMINING DENTIST</b></p> <hr/> <table border="1" style="width:100%"> <tr> <td style="width:80%"><b>5. SIGNATURE OF EXAMINING DENTIST</b></td> <td style="width:20%"><b>6. DATE SIGNED</b></td> </tr> </table> <hr/> <p><b>7. EXAMINING FACILITY</b></p> <p>NAME</p> <hr/> <p>ADDRESS</p> <hr/> <p><b>NOTE:</b> If examinee has a questionable occlusal relationship, forward diagnostic casts to: DODMERB/DB 8034 Edgerton Drive, Suite 132 USAF Academy CO 80840-2200</p>	<b>5. SIGNATURE OF EXAMINING DENTIST</b>	<b>6. DATE SIGNED</b>
<b>5. SIGNATURE OF EXAMINING DENTIST</b>	<b>6. DATE SIGNED</b>		

**8. GENERAL** *(X Yes or No for each question.)*

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	DENTAL CARIES <i>(Indicate on chart, do not chart incipienties.)</i>
<input type="checkbox"/>	<input type="checkbox"/>	MISSING TEETH, OTHER THAN THIRD MOLARS <i>(Indicate on chart by marking "X" through the roots.)</i>
<input type="checkbox"/>	<input type="checkbox"/>	NON-RESTORABLE TEETH <i>(Indicate on chart by drawing two vertical lines through tooth.)</i>
<input type="checkbox"/>	<input type="checkbox"/>	UNERUPTED TEETH <i>(Draw circle around the tooth on the chart and indicate position by an arrow.)</i>
<input type="checkbox"/>	<input type="checkbox"/>	DEVELOPMENTAL DISTURBANCES IN TEETH <i>(Significant enamel hypoplasias, amelogenesis imperfecta, dentinogenesis imperfecta, etc.)</i>
<input type="checkbox"/>	<input type="checkbox"/>	STAINED TEETH <i>(Intrinsic, unsightly)</i>

**9. HISTORY OF ORAL DISEASE, TUMOR OR ANY OTHER ABNORMALITY OF THE ORAL CAVITY** *(X Yes or No for each question. If additional space is needed, use "REMARKS" section.)*

<input type="checkbox"/>	<input type="checkbox"/>	HAS THE EXAMINEE EVER HAD A CYST OR TUMOR REMOVED FROM THE MOUTH OR JAWS? <i>(If so, describe.)</i>
<input type="checkbox"/>	<input type="checkbox"/>	HISTORY OF ABNORMAL BLEEDING OF THE ORAL TISSUES <i>(Describe)</i>
<input type="checkbox"/>	<input type="checkbox"/>	ORAL ULCERATIONS, SOFT TISSUE LESIONS, ETC. <i>(Describe)</i>
<input type="checkbox"/>	<input type="checkbox"/>	HISTORY OF CLEFT LIP
<input type="checkbox"/>	<input type="checkbox"/>	HISTORY OF CLEFT PALATE
<input type="checkbox"/>	<input type="checkbox"/>	IF YES, IS THERE AN ORO-NASAL OR ORO-ANTRAL FISTULA PRESENT?
<input type="checkbox"/>	<input type="checkbox"/>	HISTORY OF TMJ DISEASE OR PAIN <i>(Describe)</i>

*(Continued on reverse side)*



# PHYSICAL EXAM ROUTING SHEET

NAME: \_\_\_\_\_

RANK/UNIT: \_\_\_\_\_

LASSN: \_\_\_\_\_

LOCATION; TODAY'S DATE: \_\_\_\_\_

1<sup>ST</sup> FLOOR JULIE HILL (CHCS/DMIS INPUT) \_\_\_\_\_

3<sup>RD</sup> FLOOR DENTAL: \_\_\_\_\_

BASEMENT LAB: \_\_\_\_\_

BASEMENT X-RAY: \_\_\_\_\_

BASEMENT INTERNAL MONITORING \_\_\_\_\_

1<sup>ST</sup> FLOOR AUDIO: \_\_\_\_\_

1<sup>ST</sup> FLOOR OPT: \_\_\_\_\_

1<sup>ST</sup> FLOOR VITAL SIGNS \_\_\_\_\_

1<sup>ST</sup> FLOOR EKG: \_\_\_\_\_

PREV MED \_\_\_\_\_

\_\_\_\_\_

TYPE OF PHYSICAL \_\_\_\_\_

PART II DATE/TIME \_\_\_\_\_

PROVIDER \_\_\_\_\_

NOTES: \_\_\_\_\_