

MED BOARD PHYSICAL CHECK OFF SHEET

CHECK-IN

Height in Inches	Weight	Blood Pressure	Temp	Pulse
		/		

1. **FORMS- Fill out all forms completely. Please use BLACK INK only!**
2. **DENTAL – 2nd Deck, Top of Spiral Staircase**
 Class: _____
 Last Exam: (MM/YY) _____
3. **OPTOMETRY SCREENING – 1st Deck, Hallway 1J (Hours are 1300-1500 Mon, Tue & Fri.)**
 Glasses/Contacts: Y / N 2 Pair Glasses Y/N Gasmask insert Y/N
 Date of last exam: _____ (If visual acuity is worse than 20/40 have patient make appointment with optometry clinic.)
4. **HEARING EXAM – 1st Deck, Hallway 1J (0800-1100 M-F)**
 Termination Audiogram.

5. **LABORATORY – 1st Deck (at bottom of Spiral Staircase to Your Right)**

Must receive the Labs highlighted. Please ensure sign off is complete by stamp or signature.

HIV (with in 1 year)	FBS	CBC W/O Diff	SCT	Urinalysis
LIPID	RPR	WELL WOMEN	1-866-NAVYMED	G6PD
MAMMOGRAM	PSA	DNA	BT	

6. **IMMUNIZATION – 1st Deck Hallway 1F**

Must receive shot(s) highlighted. Please ensure sign off is completed by stamp or signature.

HAV#1	TWINRIX#1	YF	
HAV#2	TWINRIX#2	MMR	
HBV#1	TWINRIX#3	PPD	<u>Results</u>
HBV#2	TYPHOID	IPV	
HBV#3	TD	MENINGO	

7. **EKG - Please arrive 15 minutes prior to appointment time for your EKG.**
8. **PART 2- Appointment Time/Date: _____ Provider Name: _____**
 - a. An appointment will be made after all highlighted areas and attached **FORMS HAVE BEEN COMPLETED.**
 - b. After your physical is completed return to Physical Exam to have copies made of your physical.
9. **RETURN THIS SHEET TO MEDICAL READINESS FOR UPDATES: _____**

PATIENTS NAME (Last, First, Middle initial)	
CONTACT NUMBER	() -
SSN	20/
DATE	

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 enlist, 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, Apt Number, City, State and Zip Code)

5. HOME PHONE NUMBER

6. GRADE

7. DATE OF BIRTH
(YYYYMMDD)

8. AGE

9. SEX

Female
 Male

10. RACE

Am. Indian / Alaskan Native
 Black

Hispanic

Asian / Pacific Islander
 White

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

b. TOTAL FLYING TIME

c. LAST SIX MONTHS

15. a. SERVICE

b. COMPONENT

c. PURPOSE OF EXAMINATION

Army
 Navy
 Marine Corps
 Air Force
 Coast Guard

Active Duty
 Reserve
 National Guard

Enlistment
 Commission
 Retention
 Separation
 Medical Board

Retirement
 US Service Academy
 ROTC Scholarship Prog
 Dive Physical
 Jump Physical

16. NAME OF EXAMINING LOCATION AND ADDRESS

NHC QUANTICO
3259 CATLIN AVE
QUANTICO, VA 22134
Ph: (703) 784-1732

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

	Normal	Ab-normal	NE
17. Head, face, neck, and scalp			
18. Nose			
19. Sinuses			
20. Mouth			
21. Ears - General (Int. and ext. canals/Auditory activity under item 72)			
22. Drum (Perforation)			
23. Eyes - General (Visual acuity and refraction under items 62 - 71)			
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 breast)			
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			
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. NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

#37: Marks and scars

- 1.
- 2.
- 3.

43. DENTAL DEFECTS AND DISEASE (Please explain. Use dental form if completed by dentist.)

Acceptable
 Not Acceptable Class: _____
(Dental examination not done by dental officer)

44. FEET (Circle category)

Normal Arch	Mild	Asymptomatic
Pes Cavus	Moderate	Symptomatic
Pes Planus	Severe	

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

LABORATORY FINDINGS

45. URINALYSIS SP.GR:	a. Albumin b. Sugar	46. URINE HCG	47. HCT/Hemaglobin	48. BLOOD TYPE (POS/ NEG)
TESTS	RESULTS	HIV SPECIMEN ID LABEL		DRUG TEST SPECIMEN ID LABEL
49. HIV		Refer to NAVMED 6000/2		
50. DRUGS		in the left hand side of		
51. ALCOHOL		NAVMED 6150/series		
52. OTHER				
a. PAP SMEAR				
b. RPR (Serology)	Non-Reactive/ Reactive			
c. Electrocardiogram				

MEASUREMENTS AND OTHER FINDINGS

53. HEIGHT	54. WEIGHT	55. MIN WT - MAX WT	MAX BF%	56. TEMPERATURE	57. PULSE
58. BLOOD PRESSURE			59. RED / GREEN (Army only)	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	by	Right 20/
Left 20/	Corr. to 20/	By S.	CX	by	Left 20/
64. HETEROPHORIA (Specify distance)					
ES	EX	R.H	L.H.	Prism div.	Prism Conv.
				CT	Medical Dept
65. ACCOMMODATION		66. COLOR VISION (Test used and results)		67. DEPTH PERCEPTION (Test used and score) VERHOEFF	
Right	Left	PIP	/14	Uncorr.	Corr.
68. FIELD OF VISION			69. NIGHT VISION (Test used and score)		70. INTRAOCULAR TENSION CT
by Confrontation			NIBH		O.D. mmHg O.S. mmHg
71.a. AUDIOMETER Unit Serial Number			71.b. Unit Serial Number		
Date Calibrated (YYYYMMDD)			Date Calibrated (YYYYMMDD)		
HZ	500	1000	2000	3000	4000
Right					
Left					

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

52.d. LIPID PANEL	72.a. READING ALOUD TEST
Cholesterol: _____	<input type="checkbox"/> SAT <input type="checkbox"/> UNSAT
Triglycerides: _____	
HDL: _____	72.b. VALSALVA
LDL: _____	<input type="checkbox"/> SAT <input type="checkbox"/> UNSAT
Chol / HDL Ratio: _____	
FBS: _____	
G6PD: _____	
SICKLE CELL: _____	

52.e. CHEST X-RAY

Date: _____

Results: _____

Exam #: _____

52.f. CBC

HGB	PLT
WBC	HCT

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

74.a. EXAMINEE / APPLICANT (Check one)	75. I have been advised of my disqualifying condition.	
<input type="checkbox"/> IS QUALIFIED FOR SERVICE	a. SIGNATURE OF EXAMINEE	b. DATE (YYYYMMDD)
<input type="checkbox"/> IS NOT QUALIFIED FOR SERVICE		

74.b. PHYSICAL PROFILE								
P	U	L	H	E	S	X	PROFILER INITIALS	DATE (YYYYMMDD)

76. SIGNIFICANT OR DISQUALIFYING DEFECTS									
ITEM NO.	MEDICAL CONDITION / DIAGNOSIS	ICD9	PROFILE	RBJ DATE	QUALI	DIS-	EXAMINER	WAIVER RECEIVED	
		CODE	SERIAL	YYMMDD	FIED	QUALI FIED	INITIALS	SERVICE	DATE

77. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers) (Use additional sheets if necessary.)

78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify) (Use additional sheets if necessary.)

79. MEPS WORKLOAD (For MEPS use only)							
WKID	ST	DATE (YYYYMMDD)	INITIAL	WKID	ST	DATE (YYYYMMDD)	INITIAL

80. MED INSPECTION DATE	HT	WT	%BF	MAX.WT	HCG	QUAL	DISC	PHYSICIAN'S SIGNATURE

81.a. TYPE OR PRINT NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE
82.a. TYPE OR PRINT NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE
83.a. TYPE OR PRINT NAME OF DENTIST OR PHYSICIAN (Indicate which)	b. SIGNATURE
84.a. TYPE OR PRINT NAME OF REVIEWING OFFICER/APPROVING AUTHORITY	b. SIGNATURE

85. This examination has been administratively reviewed for completeness and accuracy.		
a. SIGNATURE	b. GRADE	c. DATE (YYYYMMDD)

86. WAIVER GRANTED (If yes, date and by whom)	87. NO. OF ATTCHED SHEETS
<input type="checkbox"/> YES	
<input type="checkbox"/> NO	

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"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> ROTC Scholarship Program	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		YES	NO
10.a. Tuberculosis	<input type="radio"/>	<input type="radio"/>	12. (Continued)	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input type="radio"/>	f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<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"/>
f. Bronchitis	<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"/>
g. Wheezing or problems with wheezing	<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"/>
h. Been prescribed or used an inhaler	<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<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"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (cracked or fractured)	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>	e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input type="radio"/>	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood 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"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<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"/>
			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."

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