

REPORT OF MEDICAL EXAMINATION	1. DATE OF EXAMINATION <i>(YYYYMMDD)</i>	2. SOCIAL SECURITY NUMBER
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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 <i>(Street, Apartment Number, City, State and ZIP Code)</i>	5. HOME TELEPHONE NUMBER <i>(Include Area Code)</i>
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6. GRADE	7. DATE OF BIRTH <i>(YYYYMMDD)</i>	8. AGE	9. SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	10. RACE <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> White
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11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY b. CIVILIAN	12. AGENCY <i>(Non-Service Members Only)</i>	13. ORGANIZATION UNIT AND UIC/CODE
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14.a. RATING OR SPECIALTY <i>(Aviators Only)</i>	b. TOTAL FLYING TIME	c. LAST SIX MONTHS
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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"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other <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	16. NAME OF EXAMINING LOCATION, AND ADDRESS <i>(Include ZIP Code)</i>
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CLINICAL EVALUATION *(Check each item in appropriate column. Enter "NE" if not evaluated.)*

	Nor- mal	Ab- norm	NE	42. NOTES: <i>(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)</i>
17. Head, face, neck, and scalp				
18. Nose				
19. Sinuses				
20. Mouth and throat				
21. Ears - General <i>(Int. and ext. canals/Auditory acuity under item 72)</i>				
22. Drum <i>(Perforation)</i>				
23. Eyes - General <i>(Visual acuity and refraction under items 62 - 71)</i>				
24. Ophthalmoscopic				
25. Pupils <i>(Equality and reaction)</i>				
26. Ocular motility <i>(Associated parallel movements, nystagmus)</i>				
27. Heart <i>(Thrust, size, rhythm, sounds)</i>				
28. Lungs and chest <i>(Include breasts)</i>				
29. Vascular system <i>(Varicosities, etc.)</i>				
30. Anus and rectum <i>(Hemorrhoids, Fistulae) (Prostate if indicated)</i>				
31. Abdomen and viscera <i>(Include hernia)</i>				
32. External genitalia <i>(Genitourinary)</i>				
33. Upper extremities				
34. Lower extremities <i>(Except feet)</i>				
35. Feet				
36. Spine, other musculoskeletal				
37. Identifying body marks, scars, tattoos				
38. Skin, lymphatics				
39. Neurologic				
40. Psychiatric <i>(Specify any personality deviation)</i>				
41. Pelvic <i>(Females only)</i>				

43. DENTAL DEFECTS AND DISEASE <i>(Please explain. Use dental form if completed by dentist.)</i> <input type="checkbox"/> Acceptable <input type="checkbox"/> Not Acceptable Class _____ <i>(Dental examination not done by dental officer)</i>	44. FEET <i>(Circle category)</i> <table style="width:100%;"> <tr> <td>Normal Arch</td> <td>Mild</td> <td>Asymptomatic</td> </tr> <tr> <td>Pes Cavus</td> <td>Moderate</td> <td></td> </tr> <tr> <td>Pes Planus</td> <td>Severe</td> <td>Symptomatic</td> </tr> </table>	Normal Arch	Mild	Asymptomatic	Pes Cavus	Moderate		Pes Planus	Severe	Symptomatic
Normal Arch	Mild	Asymptomatic								
Pes Cavus	Moderate									
Pes Planus	Severe	Symptomatic								

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LABORATORY FINDINGS				
45. URINALYSIS	a. Albumin	46. URINE HCG	47. H/H	48. BLOOD TYPE
	b. Sugar			
TESTS	RESULTS	HIV SPECIMEN ID LABEL		DRUG TEST SPECIMEN ID LABEL
49. HIV				
50. DRUGS				
51. ALCOHOL				
52. OTHER				
a. PAP SMEAR				
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	by	Right 20/	Corr. to 20/	by								
Left 20/	Corr. to 20/	By	S.	CX	by	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) AFVT</i>										
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		SAT	UNSAT
Right							Right								72b. VALSALVA	
Left							Left								SAT	UNSAT

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

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74.a. EXAMINEE/APPLICANT <i>(check one)</i> <input type="checkbox"/> IS QUALIFIED FOR SERVICE <input type="checkbox"/> IS NOT QUALIFIED FOR SERVICE	75. I have been advised of my disqualifying condition. a. SIGNATURE OF EXAMINEE	b. DATE (YYYYMMDD)
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b. PHYSICAL PROFILE									
P	U	L	H	E	S	X	PROFILER INITIALS	DATE (YYYYMMDD)	

76. SIGNIFICANT OR DISQUALIFYING DEFECTS										
ITEM NO.	MEDICAL CONDITION/DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE (YYYYMMDD)	QUALIFIED	DIS-QUALIFIED	EXAMINER INITIALS	WAIVER RECEIVED		
								SERVICE	DATE (YYYYMMDD)	

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 <i>(For MEPS use only)</i>							
WKID	ST	DATE (YYYYMMDD)	INITIAL	WKID	ST	DATE (YYYYMMDD)	INITIAL

80. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	PHYSICIAN'S SIGNATURE

81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE
82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE
83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN <i>(Indicate which)</i>	b. SIGNATURE
84.a. TYPED OR PRINTED 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 <i>(If yes, date and by whom)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO	87. NUMBER OF ATTACHED SHEETS
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