CGs, DDGs & FFGs
Separation & Retirement Physicals
MRD Clinic, Wednesdays@1230
Located next to Optometry in the 32nd St Branch Medical
Clinic BLDG 3300

Your IDC must review and sign your physical paperwork prior to seeing the MRD physician for final sign-off. If you present to Wednesday physicals clinic without your IDC’s signature on this form, you will be sent back to your ship.

At a minimum, you must complete:
_____ Audiogram within 1 year
_____ Dental Officer’s signature on SF-600 coversheet
_____ PHA completed within 1 year, and placed in medical record.
_____ (with PPD results or NAVMED 6224/8 form completed in record)
_____ Optometry evaluation within 2 years if you wear glasses or contacts
_____ Optional Hepatitis C screening lab only if you are 35 and older
_____ Meet with your IDC, and have them sign/stamp below

_________________________________________  ____________________________
Sailor name  Ship

IDC Section:

I have addressed each line item marked yes on this DD 2807, completed this SF 2697, reviewed, recorded and addressed all indicated labs and studies. I have signed and stamped all documents.

_________________________________________  ____________________________
IDC signature and stamp  Date
**SEPARATION/RETIREMENT SF-600**

**DATE OF LAST PHA:**

**DATE OF LAST PPD or NAVMED 6224/8 FORM:** ____________ **RESULTS:** ____________

**HIV DATE:** ____________ **AUDIOGRAM DATE:** ____________

**P:**

**LAST OPTOMETRY EXAM (IF WEARING GLASSES/CONTACTS):** ____________

**T:**

* **FEMALES ONLY:**

**DATE OF LAST WELL-WOMAN EXAM:** ____________

**DATE OF LAST MAMMOGRAM (over 40 y/o):** ____________

* **Meds:**

  I have been informed and understand the provisions of chap. 15-29 of the MANMED.

**PATIENT SIGNATURE:** ____________ **DATE:** ____________

* **IDC:**

  A complete health record screen was conducted this date IAW MANMED CH. 15-29 and BUMED 6230
  Dated Dec 14, 2001. Documentation has been reviewed for completeness and accuracy:

**Allergies:**

**NAME/SIGNATURE:** ____________ **DATE:** ____________

* **DENTAL OFFICER:**

  Member’s dental record reviewed.

**Tobacco:**

1. **MEMBER IS QUALIFIED / NOT QUALIFIED for SEPARATION / RETIREMENT**

2. **COMMENTS**

**ETOH:**

**NAME/SIGNATURE:** ____________ **DATE:** ____________

* **MEDICAL OFFICER:**

  Member’s medical record reviewed.

1. **MEMBER IS FOUND PHYSICALLY QUALIFIED / NOT QUALIFIED for SEPARATION / RETIREMENT**

2. **COMMENTS**

**HOSPITAL OR MEDICAL FACILITY**

CNSP-MRD Clinic  NB San Diego

**STATUS**

ACTIVE

**DEPARTMENT/ SERVICE**

DOD/USN

**RECORDS MAINTAINED AT**

SAME

**SPONSOR’S NAME**

SELF

**SSN/ID NO. (Fill in you SSN Here)**

**RELATIONSHIP TO SPONSOR**

NONE

**NAME:**

**SSN:** 20/

**DOB:**

**RATE / RANK:**

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

**MEDICAL RECORD**

STANDARD FORM 600 (REV. 6-97)

PRESCRIBED BY GS/AICMR

FIRM (41 CFR) 201-9:202-1
Hepatitis C Virus (HCV) Antibody Screening at Separation or Retirement Physical Examination

Screening for the presence of antibodies to Hepatitis C Virus (HCV) is offered to all Navy and Marine Corps Service Personnel over the age of 35 years upon their retirement or separation. This screening is not mandatory.

Hepatitis C is transmitted primarily by injections of contaminated blood. The following are possible sources of hepatitis C infection. If you can answer “yes” to any of these risk factors, you should receive a simple blood test to determine if you could have hepatitis C.

- Receiving a transfusion of blood or blood products before 1992.
- Ever injecting illegal drugs, including use once many years ago.
- Receiving clotting factor concentrates products before 1987.
- Having chronic (long term) hemodialysis
- Being told that you have persistently abnormal liver enzymes tests or an unexpected liver disease.
- Having a needle stick, sharps, or mucosal exposure to potentially HCV infected blood as part of your occupation or duties and not previously evaluated for HCV infection.

If you consider yourself at risk, based on an exposure to a possible source of hepatitis C virus, you should have a simple blood test for hepatitis C virus infection (HCV antibody test). You may request HCV testing even if you don’t have a specific risk factor for infection. You will not be asked to identify any specific risk factors to justify HCV testing.

If the test is positive, you will receive a medical evaluation to confirm HCV infection, determine your need for specific treatments and be provided counseling on lifestyle modifications and steps to protect others from infection.

(Circle One) No – I do not want to be tested for Hepatitis C    Yes – I want to be tested for Hepatitis C

Indicate by your signature that you understand the foregoing statement.

SIGNATURE:    DATE:
## REPORT OF MEDICAL HISTORY
(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

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 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.

### PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 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.

---

### X ALL APPLICABLE BOXES:

**6.a. SERVICE**
- [ ] Army
- [ ] Navy
- [ ] Marine Corps
- [ ] Air Force

**b. COMPONENT**
- [ ] Active Duty
- [ ] Reserve
- [ ] National Guard

**c. PURPOSE OF EXAMINATION**
- [ ] Medical Board
- [ ] Other (Specify)
- [ ] Retirement
- [ ] U.S. Service Academy
- [ ] ROTC Scholarship Program

**7.a. POSITION**
- [ ] (Title, Grade, Component)
- [ ] b. USUAL OCCUPATION

### 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.**

### 10. TUBERCULOSIS

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

### 11. SEVERE TOOTH OR GUM TROUBLE

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

### 12. PAINFUL SHOULDER, ELBOW OR WRIST (E.G., PAIN, DISLOCATION, ETC.)

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

### 13. FREQUENT INDIGESTION OR HEARTBURN

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

### 14. ADVERSE REACTION TO SERUM, FOOD, INSECT STINGS OR MEDICINE

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

<table>
<thead>
<tr>
<th>Item</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.a. Dizziness or fainting spells</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>15.b. Frequent or severe headache</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>15.c. A head injury, memory loss or amnesia</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>15.d. Paralysis</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>15.e. Seizures, convulsions, epilepsy or fits</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>15.f. Car, train, sea, or air sickness</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>15.g. A period of unconsciousness or concussion</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>15.h. Meningitis, encephalitis, or other neurological problems</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

#### 16.a. Rheumatic fever | ☐ | ☐ |
| 16.b. Prolonged bleeding (as after an injury or tooth extraction, etc.) | ☐ | ☐ |
| 16.c. Pain or pressure in the chest | ☐ | ☐ |
| 16.d. Palpitation, pounding heart or abnormal heartbeat | ☐ | ☐ |
| 16.e. Heart trouble or murmur | ☐ | ☐ |
| 16.f. High or low blood pressure | ☐ | ☐ |

#### 17.a. Nervous trouble of any sort (anxiety or panic attacks) | ☐ | ☐ |
| 17.b. Habitual stammering or stuttering | ☐ | ☐ |
| 17.c. Loss of memory or amnesia, or neurological symptoms | ☐ | ☐ |
| 17.d. Frequent trouble sleeping | ☐ | ☐ |
| 17.e. Received counseling of any type | ☐ | ☐ |
| 17.f. Depression or excessive worry | ☐ | ☐ |
| 17.g. Been evaluated or treated for a mental condition | ☐ | ☐ |
| 17.h. Attempted suicide | ☐ | ☐ |
| 17.i. Used illegal drugs or abused prescription drugs | ☐ | ☐ |

#### 18. FEMALES ONLY. Have you ever had or do you now have:

<table>
<thead>
<tr>
<th>Item</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.a. Treatment for a gynecological (female) disorder</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>18.b. A change of menstrual pattern</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>18.c. Any abnormal PAP smears</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>18.d. First day of last menstrual period (YYYYMMDD)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>18.e. Date of last PAP smear (YYYYMMDD)</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

#### 19. Have you been refused employment or been unable to hold a job or stay in school because of:

<table>
<thead>
<tr>
<th>Item</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.a. Sensitivity to chemicals, dust, sunlight, etc.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>19.b. Inability to perform certain motions</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>19.c. Inability to stand, sit, kneel, lie down, etc.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>19.d. Other medical reasons (if yes, give reasons.)</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

#### 20. Have you ever been treated in an Emergency Room? (If yes, for what?) | ☐ | ☐ |

#### 21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) | ☐ | ☐ |

#### 22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.) | ☐ | ☐ |

#### 23. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.) | ☐ | ☐ |

#### 24. Have you ever been discharged from military service for any reason? (If yes, specify when, where, and reason of discharge; whether honorable, other than honorable, for unfitness or unsuitability.) | ☐ | ☐ |

#### 25. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.) | ☐ | ☐ |

#### 26. Have you ever been denied life insurance? | ☐ | ☐ |

#### 27. Have you ever been denied life insurance? | ☐ | ☐ |

#### 28. Have you ever been advised to have any operations or surgery? (If yes, describe and give age at which occurred.) | ☐ | ☐ |

#### 29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)

---

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

**DD FORM 2807-1, MAR 2007**

Page 2 of 3 Pages
30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)

<table>
<thead>
<tr>
<th>a. COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
## REPORT OF MEDICAL ASSESSMENT

**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** (Last, First, Middle)
2. **SOCIAL SECURITY NUMBER**
3. **RANK**

4. **COMPONENT**
5. **UNIT OF ASSIGNMENT**

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

8. **DATE OF LAST PHYSICAL EXAMINATION BY THE MILITARY** (YYMMDD)
9. **DATE ENTERED ON CURRENT ACTIVE DUTY** (YYMMDD)

10. **COMPARISON TO MY LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, MY OVERALL HEALTH IS**

   - Better
   - The Same
   - 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?**

   - 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?**

   - No
   - Yes

13. **HAVE YOU SUFFERED FROM ANY INJURY OR ILLNESS WHILE ON ACTIVE DUTY FOR WHICH YOU DID NOT SEEK MEDICAL CARE?**

   - No
   - Yes

14. **ARE YOU NOW TAKING ANY 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?**

   - No
   - Yes

16. **DO YOU HAVE ANY DENTAL PROBLEMS?**

   - No
   - Yes

17. **DO YOU HAVE ANY OTHER QUESTIONS OR CONCERN ABOUT YOUR HEALTH?**

   - No
   - Yes

18. **AT THE PRESENT TIME, DO YOU INTEND TO SEEK DEPARTMENT OF VETERANS AFFAIRS (VA) DISABILITY?**

   - No
   - Yes
   - Uncertain

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

   - Signature of Service Member
   - Date Signed

---

**DD FORM 2697, FEB 95**

Designed using Perform Pro, WHS/DIOR, Feb 95.
### 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.)
- **RETIEMENT**
- **OTHER**

#### 23. MEDICAL FACILITY

#### 24. DATE OF ASSESSMENT  
(YYMMDD)

#### 25. HEALTH CARE PROVIDER

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

DD FORM 2697, FEB 95 (BACK)
# Report of Medical Examination

**1. Date of Examination**

**2. Social Security Number**

**3. Last Name - First Name - Middle Name (Suffix)**

**4. Home Address**

(Street, Apartment Number, City, State and ZIP Code)

**5. Home Telephone Number**

(Including Area Code)

**6. Grade**

**7. Date of Birth**

(YYYYMMDD)

**8. Age**

**9. Sex**

Female

Male

**10. A. Racial Category**

(Select one or more)

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

**11. Total Years Government Service**

a. Military

b. Civilian

**12. Agency**

(Non-Services Members Only)

**13. Organization Unit and UIC/Code**

**14. A. Rating or Specialty**

(Aviators Only)

b. Total Flying Time

**15. A. Service**

- Army
- Navy
- Marine Corps
- Air Force

b. Component

- Active Duty
- Reserve
- National Guard

**16. Name of Examining Location, and Address**

(Including ZIP Code)

**CLINICAL EVALUATION**

(Select each item in appropriate column. Enter "NE" if not evaluated.)

**44. Notes:**

(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

**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.)

- Acceptable
- Not Acceptable (Class_______)

**35. Feet**

(Continued) (Circle category)

- Normal Arch
- Mild
- Asymptomatic
- Pes Cavus
- Moderate
- Pes Planus
- Severe
- Symptomatic

---

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DoD exception to SF 88 approved by ICMR, August 3, 2000.
### Measurements and Other Findings

<table>
<thead>
<tr>
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<thead>
<tr>
<th>58. Blood Pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. 1st SYS.</td>
</tr>
<tr>
<td>b. 2nd SYS.</td>
</tr>
<tr>
<td>c. 3rd SYS.</td>
</tr>
<tr>
<td>a. 1st DIAS.</td>
</tr>
<tr>
<td>b. 2nd DIAS.</td>
</tr>
<tr>
<td>c. 3rd DIAS.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>59. Red/Green (Army Only)</th>
<th>60. Other Vision Test</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>62. Refraction by Autorefraction or Manifest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right 20/</td>
</tr>
<tr>
<td>Corr. to 20/</td>
</tr>
<tr>
<td>By S.</td>
</tr>
<tr>
<td>CX</td>
</tr>
<tr>
<td>Left 20/</td>
</tr>
<tr>
<td>Corr. to 20/</td>
</tr>
<tr>
<td>By S.</td>
</tr>
<tr>
<td>CX</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>63. Near Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right 20/</td>
</tr>
<tr>
<td>Corr. to 20/</td>
</tr>
<tr>
<td>by</td>
</tr>
<tr>
<td>Left 20/</td>
</tr>
<tr>
<td>Corr. to 20/</td>
</tr>
<tr>
<td>by</td>
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</table>

<table>
<thead>
<tr>
<th>64. Heterophoria (Specify Distance)</th>
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<tbody>
<tr>
<td>ES°</td>
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<td>-----</td>
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<table>
<thead>
<tr>
<th>65. Accommodation</th>
</tr>
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<tbody>
<tr>
<td>Right</td>
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<td>Left</td>
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</table>

<table>
<thead>
<tr>
<th>66. Color Vision (Test Used and Result)</th>
<th>67. Depth Perception (Test Used and Score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test</td>
<td>Uncorrected</td>
</tr>
<tr>
<td>PIP</td>
<td>/14</td>
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</tbody>
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<table>
<thead>
<tr>
<th>68. Field of Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>O.D.</td>
</tr>
<tr>
<td>O.S.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>71a. Audiometer</th>
<th>71b. Unit Serial Number</th>
<th>72a. Reading Aloud Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Calibrated (YYYYMMDD)</td>
<td>Date Calibrated (YYYYMMDD)</td>
<td></td>
</tr>
<tr>
<td>HZ</td>
<td>500</td>
<td>1000</td>
</tr>
<tr>
<td>Right</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>72b. Valsalva</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAT</td>
</tr>
</tbody>
</table>

| 73. Notes (Continued) and Significant or Interval History (Use additional sheets if necessary.) |
### PHYSICAL PROFILE

<table>
<thead>
<tr>
<th>P</th>
<th>U</th>
<th>L</th>
<th>H</th>
<th>E</th>
<th>S</th>
<th>X</th>
<th>PROFILER INITIALS</th>
<th>DATE (YYYYMMDD)</th>
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</tbody>
</table>

### SIGNIFICANT OR DISQUALIFYING DEFECTS

<table>
<thead>
<tr>
<th>ITEM NO.</th>
<th>MEDICAL CONDITION/DIAGNOSIS</th>
<th>ICD CODE</th>
<th>PROFILE SERIAL</th>
<th>RBJ DATE (YYYYMMDD)</th>
<th>QUALIFIED</th>
<th>DISQUALIFIED</th>
<th>EXAMINER INITIALS</th>
<th>WAIVER RECEIVED</th>
</tr>
</thead>
<tbody>
<tr>
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### SUMMARY OF DEFECTS AND DIAGNOSES

(List diagnoses with item numbers) (Use additional sheets if necessary.)

### RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED

(Specify) (Use additional sheets if necessary.)

### MEPS WORKLOAD

(For MEPS use only)

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### TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER

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### TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN

(Indicate which)

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### TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY

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### This examination has been administratively reviewed for completeness and accuracy.

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### WAIVER GRANTED

(If yes, date and by whom)

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DD FORM 2808, OCT 2005