

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

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING, ORGANIZATIONS <i>(Sign each entry)</i>
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	SEPARATION/RETIREMENT SF-600
BP:	DATE OF LAST PHA: _____ DATE OF LAST PPD or NAVMED 6224/8 FORM: _____ RESULTS: _____
P:	HIV DATE: _____ AUDIOGRAM DATE: _____ LAST OPTOMETRY EXAM (IF WEARING GLASSES/CONTACTS): _____ *****
T:	*
R:	FEMALES ONLY: DATE OF LAST WELL-WOMAN EXAM: _____ DATE OF LAST MAMMOGRAM (over 40 y/o): _____ *****
Meds:	PATIENT: I have been informed and understand the provisions of chap. 15-29 of the MANMED. PATIENT SIGNATURE: _____ DATE: _____ *****
Allergies:	*
	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:
Tobacco:	NAME/SIGNATURE: _____ DATE: _____ *****
	*
	DENTAL OFFICER: Member's dental record reviewed.
	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
	NAME/SIGNATURE: _____ DATE: _____

HOSPITAL OR MEDICAL FACILITY CNSP-MRD Clinic NB San Diego	STATUS ACTIVE	DEPART./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 GSA/ICMR FIRMR (41 CFR) 201-9.202-1
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HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
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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.
- Receiving an organ transplant before July 1992.
- 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:

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS MAINTAINED AT:			
PATIENT'S NAME (Last, First, Middle initial)	SEX		
	F		
RELATIONSHIP TO SPONSOR:	STATUS	RANK/GRADE	
SPONSOR'S NAME		ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRT	

REPORT OF MEDICAL HISTORY (This information is for official and medically confidential use only and will not be released to unauthorized persons.)	OMB No. 0704-0413 OMB approval expires Mar 31, 2010
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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.

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) CNSP MRD Clinic 2450 Craven Street Naval Base San Diego BLDG 3300 San Diego, CA 92136	
b. HOME TELEPHONE (Include Area Code)		

X ALL APPLICABLE BOXES:

<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%; padding: 5px;">6.a. SERVICE</td> <td style="width:20%; padding: 5px;">6. COMPONENT</td> <td style="width:40%; padding: 5px;">6.c. PURPOSE OF EXAMINATION</td> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force </td> <td style="padding: 5px;"> <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard </td> <td style="padding: 5px;"> <input type="checkbox"/> Enlistment <input type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program </td> </tr> </table>	6.a. SERVICE	6. COMPONENT	6.c. PURPOSE OF EXAMINATION	<input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	<input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	<input type="checkbox"/> Enlistment <input type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program	7.a. POSITION (Title, Grade, Component) b. USUAL OCCUPATION
6.a. SERVICE	6. COMPONENT	6.c. PURPOSE OF EXAMINATION					
<input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	<input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	<input type="checkbox"/> Enlistment <input type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program					

8. CURRENT MEDICATIONS (Prescription and Over-the-counter)	9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)
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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	○	○	f. Foot trouble (e.g., pain, corns, bunions, etc.)	○	○
b. Lived with someone who had tuberculosis	○	○	g. Impaired use of arms, legs, hands, or feet	○	○
c. Coughed up blood	○	○	h. Swollen or painful joint(s)	○	○
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	○	○	i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	○	○
e. Shortness of breath	○	○	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	○	○
f. Bronchitis	○	○	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	○	○
g. Wheezing or problems with wheezing	○	○	l. Bone, joint, or other deformity	○	○
h. Been prescribed or used an inhaler	○	○	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	○	○
i. A chronic cough or cough at night	○	○	n. Broken bone(s) (cracked or fractured)	○	○
j. Sinusitis	○	○	13.a. Frequent indigestion or heartburn	○	○
k. Hay fever	○	○	b. Stomach, liver, intestinal trouble, or ulcer	○	○
l. Chronic or frequent colds	○	○	c. Gall bladder trouble or gallstones	○	○
11.a. Severe tooth or gum trouble	○	○	d. Jaundice or hepatitis (liver disease)	○	○
b. Thyroid trouble or goiter	○	○	e. Rupture/hernia	○	○
c. Eye disorder or trouble	○	○	f. Rectal disease, hemorrhoids or blood from the rectum	○	○
d. Ear, nose, or throat trouble	○	○	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	○	○
e. Loss of vision in either eye	○	○	h. Frequent or painful urination	○	○
f. Worn contact lenses or glasses	○	○	i. High or low blood sugar	○	○
g. A hearing loss or wear a hearing aid	○	○	j. Kidney stone or blood in urine	○	○
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	○	○	k. Sugar or protein in urine	○	○
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	○	○	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	○	○
b. Arthritis, rheumatism, or bursitis	○	○	14.a. Adverse reaction to serum, food, insect stings or medicine	○	○
c. Recurrent back pain or any back problem	○	○	b. Recent unexplained gain or loss of weight	○	○
d. Numbness or tingling	○	○	c. Currently in good health (If no, explain in Item 29 on Page 2.)	○	○
e. Loss of finger or toe	○	○	d. Tumor, growth, cyst, or cancer	○	○

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
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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:			
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>		
g. A period of unconsciousness or concussion	<input type="radio"/>	<input type="radio"/>				
h. Meningitis, encephalitis, or other neurological problems	<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>		
16.a. Rheumatic fever	<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"/>				
c. Pain or pressure in the chest	<input type="radio"/>	<input type="radio"/>				
d. Palpitation, pounding heart or abnormal heartbeat	<input type="radio"/>	<input type="radio"/>				
e. Heart trouble or murmur	<input type="radio"/>	<input type="radio"/>				
f. High or low blood pressure	<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>			
17.a. Nervous trouble of any sort <i>(anxiety or panic attacks)</i>	<input type="radio"/>	<input type="radio"/>				
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"/>	23. Have you ever had any illness or injury other than those already noted? <i>(If yes, specify when, where, and give details.)</i>			
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>			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>			
e. Date of last PAP smear <i>(YYYYMMDD)</i>						
			25. Have you ever been rejected for military service for any reason? <i>(If yes, give date and reason for rejection.)</i>			
					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>	
			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>			
					28. Have you ever been denied life insurance?	

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."

REPORT OF MEDICAL ASSESSMENT				REPORT CONTROL SYMBOL DD-HA(AR)1939	
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 (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. COMPARED TO MY LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, MY OVERALL HEALTH IS (X one. If "Worse," explain.)					
<input type="checkbox"/> THE SAME					
<input type="checkbox"/> BETTER					
<input type="checkbox"/> 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.)					
<input type="checkbox"/> NO					
<input type="checkbox"/> 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.)					
<input type="checkbox"/> NO					
<input type="checkbox"/> 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.)					
<input type="checkbox"/> NO					
<input type="checkbox"/> YES					
14. ARE YOU NOW TAKING ANY MEDICATIONS? (X one. If "Yes," list medications.)					
<input type="checkbox"/> NO					
<input type="checkbox"/> 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.)					
<input type="checkbox"/> NO					
<input type="checkbox"/> YES					
16. DO YOU HAVE ANY DENTAL PROBLEMS? (X one. If "Yes," explain.)					
<input type="checkbox"/> NO					
<input type="checkbox"/> YES					
17. DO YOU HAVE ANY OTHER QUESTIONS OR CONCERN ABOUT YOUR HEALTH? (X one. If "Yes," explain.)					
<input type="checkbox"/> NO					
<input type="checkbox"/> 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.)					
<input type="checkbox"/> NO					
<input type="checkbox"/> YES					
<input type="checkbox"/> 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**

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.a. RACIAL CATEGORY <i>(X one or more)</i> <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	b. ETHNIC CATEGORY <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino
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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	44. 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 71)</i>					
22. Drums <i>(Perforation)</i>					
23. Eyes - General <i>(Visual acuity and refraction under items 61 - 63)</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 <i>(See Item 35 Continued)</i>					
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>					
42. Endocrine					
43. DENTAL DEFECTS AND DISEASE <i>(Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in Item 44.)</i>					35. FEET <i>(Continued) (Circle category)</i>
<input type="checkbox"/> Acceptable					Normal Arch Mild Asymptomatic
<input type="checkbox"/> Not Acceptable Class _____					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. 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 (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		Right 20/		Corr. to 20/		by			
Left 20/		Corr. to 20/		By		S.		CX		Left 20/		Corr. to 20/		by			
64. HETEROPHORIA (Specify distance)																	
ES °		EX °		R.H.		L.H.		Prism div.		Prism Conv CT		NPR		PD			
65. ACCOMMODATION				66. COLOR VISION (Test used and result)				67. DEPTH PERCEPTION (Test used and score) AFVT									
Right		Left		PIP /14				Uncorrected		Corrected							
68. FIELD OF VISION				69. NIGHT VISION (Test used and score)				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		
Right								Right									
Left								Left									
72b. VALSALVA																	
SAT <input type="checkbox"/> UNSAT <input type="checkbox"/>																	
73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY (Use additional sheets if necessary.)																	

