Checklist for SOF/ EOD/ DIVE/ SUB/ DOME Physical Exams

The following list of twelve items must be completed prior to a review by the Diving Medical Officer. All relevant paperwork must accompany the DD2808, DD2807, NAVPERS 1200/6 and NAVMED 6150/2

☐ **12 Lead EKG: within 90 days of exam date.** - will be performed by dive corpsman at screening exam.

☐ **Chest X-ray: PA and Lateral within 90 days of exam date.**

☐ **Labs: all within 90 days of exam date! These are fasting labs!**

- **CBC,**
- **Lipid + Glucose (do not eat 12 hours before labs are drawn, you may drink water/coffee)**
- **UA + UA Micro,**
- **Hep C screening,**
- **HIV**
- **PSA (required for anyone age 40 or older)**

☐ **Dental: must be class I or II**

- Dental Officer to complete Blocks #43 & 83 of DD FORM 2808, must have date of exam on page three of NAVPERS 1200/6 box 5.

☐ **Audiogram: within 90 days of exam date.**

- Documented on Block #71 of DD FORM 2808
- Need to report documenting make, model, serial number, and date of last calibration of the machine used

☐ **Optometry: testing within 90 days date.**

- Must include: distant and near visual acuity with correction and refraction if needed, field of vision, and color vision
- Must include depth perception.
- IOP necessary if you are age 40 years or older

☐ **Immunizations: must be up to date**

- **PPD test** within **90 days!**
- Must include: typhoid, yellow fever, tetanus, polio, MMR, Hep-A and Hep-B
- G6PD, blood type/Rh, and Sickle Cell Test

Screen the member's entire health record for disqualifying medical conditions (refer to NAVMED P-117, chapter 15).

ANY QUESTIONS PLEASE CALL **619-545-6210** AND ASK FOR THE DIVE OFFICE

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 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 INITIAL	4. HOME ADDRESS *(Street, Apartment Number, City, State, ZIP code)*	5. TELEPHONE NUMBER

6. GRADE	7. DATE OF BIRTH	8. AGE	9. SEX	10.a. RACIAL CATEGORY *(Check one or more)*			b. ETHNIC CATEGORY
			☐ M ☐ F	☐ Black or African American ☐ Asian ☐ White	American Indian or Alaska Native Native Hawaiian or Other Pacific Islander		☐ Hispanic/Latino ☐ Not Hispanic/Latino

11. TOTAL YEARS GOV'T SERVICE		12. AGENCY *(Non-Service Members Only)*	13. ORGANIZATION UNIT AND UIC/CODE
a. MILITARY	b. CIVILIAN		

14.A. RATING OR SPECIALTY *(Aviators Only)*	b. TOTAL FLYING TIME	c. LAST SIX MONTHS

15.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION			16. NAME OF EXAMINING LOCATION AND ADDRESS
☐ Army ☐ Coast Guard ☐ Navy ☐ Marine Corps ☐ Air Force	☐ Active Duty ☐ Reserve ☐ National Guard	☐ Enlistment ☐ Commission ☐ Retention ☐ Separation	☐ Medical Board ☐ Retirement ☐ Academy/ROTC ☐ SUB	DIVE NSW/SO MFF NFD	Branch Medical Clinic, Naval Base Coronado, BLDG. 601 McCain BLVD San Diego, CA 92135 Phone 619-545-5545

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

	Normal	Abnorm	NE
17. Head, face, neck, and scalp			
18. Nose			
19. Sinuses			
20. Mouth and throat			
21. Ears - General *(Int. and ext. canals/Auditory acuity under item 71)*			
22. Drums *(Perforation)*			
23. Eyes - General *(Visual acuity and refraction under items 61 - 63)*			
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 breasts)*			
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 *(See Item 35 continued)*			
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. Endocrine			

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

39. IN DETAIL:
Cranial Nerves: II-XII Intact and Symmetric - Yes/ No
Strength: 5/5 B/L UE & LE Throughout - Yes/ No
Sensation: To Light Touch B/L UE & LE Throughout - Yes/ No
Reflexes: 2+ /4 Symmetric. Bi/ Tri/ Brach/ Knee/Ankle - Yes/ No
Cerebellar: R-N, H-T, H-S, Rap, Alt, Rohm, Gait NML - Yes/ No
MS: Mood/ Affected/ Attitude Intact/NML - Yes/No
Note of deviations:

22. Valsalva Intact B/L - Yes/ No
37. Circumcised- Yes/No, list of scars, Tattoo, Body mark w/ approx size by cm:

38. Suspicious skin lesions found- Yes/ No

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 Class ☐
☐ Not Acceptable

35. FEET *(Continued) (Check each category)*

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

LAST NAME, FIRST NAME, MIDDLE INITIAL	SOCIAL SECURITY NUMBER

LABORATORY FINDINGS SEE BOX 73

45. URINALYSIS	a. Albumin	46. URINE HCG	47. H/H	48. BLOOD TYPE
	b. Sugar			

TESTS	RESULTS	HIV SPECIMEN 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	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/		Cor. to 20/		By	S.	CX	Right 20/		Cor. to 20/		by
Left 20/		Cor. to 20/		By	S.	CX	Left 20/		Cor. to 20/		by

64. HETEROPHORIA *(Specify distance)*

ES° EX° R.H. L.H. Prism div. Prism div. CT NPR PD

65. ACCOMMODATION		66. COLOR VISION *(Test used and result)*	67. DEPTH PERCEPTION *(Test used and score)* AFVT	
Right	Left	PIP / 14	Uncorrectec	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. AUDIOMETER Unit Serial Number							72a. READING ALOUD TEST			
Date Calibrated							Date Calibrated								SAT		UNSAT
HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000				
Right							Right							72b. VALSALVA			
Left							Left							x	SAT		UNSAT

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

LABS **DATE**

CBC

WBC:
HGB:
HCT:
PLT:

GLUC:

HIV:
HCV:
PPD: mm

UA

Spec Grav:
pH:
Gluc:
Prot:
Ket:
Blood:

Micro

RBC
WBC

EKG

Date:
Impression:

CXR

Date:
Exam #:
Location:
Impression:

Additional labs/x-rays/comments:

G6PD:
Sickle Cell screen:
Blood type:

Hep A series completed:
Hep B series completed:

LIPIDS:

Chol:
HDL:
LDL:
Trig:

LAST NAME, FIRST NAME, MIDDLE INITIAL	SOCIAL SECURITY NUMBER
0	

74a. EXAMINEE/APPLICANT *(Check all that apply)*

☐ IS QUALIFIED FOR SERVICE ☐ DIVE ☐ NSW/SO ☐ MFF

☐ IS NOT QUALIFIED FOR SERVICE ☐ SUB ☐ NUC ☐

75. I have been advised of my disqualifying condition.

a. SIGNATURE OF EXAMINEE	b. DATE

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)	QUALI-FIED	DIS-QUALI-FIED	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 *(For MEPS use only)*

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. TYPE OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE	DATE
82.a. TYPE OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE	DATE
83.a. TYPE OR PRINTED NAME OF DENTIST OR PHYSICIAN	b. SIGNATURE	DATE
84.a. TYPE OR PRINTED NAME OF REVIEWING OFFICER	b. SIGNATURE	DATE

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)*

☐ YES

☐ NO

87. NUMBER OF ATTACHED SHEETS ☐

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

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 confine- ment 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)*

b. HOME TELEPHONE *(Include Area Code)*

5. EXAMINING LOCATION AND ADDRESS *(Include ZIP Code)*
Branch Medical Clinic, Naval Base Coronado, BLDG. 601 McCain BLVD San Diego, CA 92135 Phone 619-545-5545

X ALL APPLICABLE BOXES:

6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION	
☐ Army ☐ Coast Guard	☐ Active Duty	☐ Enlistment	☐ Medical Board ☐ Other *(Specify)*
☐ Navy	☐ Reserve	☐ Commission	☐ Retirement
☐ Marine Corps	☐ National Guard	☐ Retention	☐ U.S. Service Academy
☐ Air Force		☐ Separation	☐ ROTC Scholarship Program

7.a. POSITION *(Title, Grade, Component)*

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
10.a. Tuberculosis	○	○
b. Lived with someone who had tuberculosis	○	○
c. Coughed up blood	○	○
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	○	○
e. Shortness of breath	○	○
f. Bronchitis	○	○
g. Wheezing or problems with wheezing	○	○
h. Been prescribed or used an inhaler	○	○
i. A chronic cough or cough at night	○	○
j. Sinusitis	○	○
k. Hay fever	○	○
l. Chronic or frequent colds	○	○
11.a. Severe tooth or gum trouble	○	○
b. Thyroid trouble or goiter	○	○
c. Eye disorder or trouble	○	○
d. Ear, nose, or throat trouble	○	○
e. Loss of vision in either eye	○	○
f. Worn contact lenses or glasses	○	○
g. A hearing loss or wear a hearing aid	○	○
h. Surgery to correct vision *(RK, PRK, LASIK, etc.)*	○	○
12.a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)*	○	○
b. Arthritis, rheumatism, or bursitis	○	○
c. Recurrent back pain or any back problem	○	○
d. Numbness or tingling	○	○
e. Loss of finger or toe	○	○

12. *(Continued)*	YES	NO
f. Foot trouble *(e.g., pain, corns, bunions, etc.)*	○	○
g. Impaired use of arms, legs, hands, or feet	○	○
h. Swollen or painful joint(s)	○	○
i. Knee trouble *(e.g., locking, giving out, pain or ligament injury, etc.)*	○	○
j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	○	○
k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	○	○
l. Bone, joint, or other deformity	○	○
m. Plate(s), screw(s), rod(s) or pin(s) in any bone	○	○
n. Broken bone(s) *(cracked or fractured)*	○	○
13.a. Frequent indigestion or heartburn	○	○
b. Stomach, liver, intestinal trouble, or ulcer	○	○
c. Gall bladder trouble or gallstones	○	○
d. Jaundice or hepatitis *(liver disease)*	○	○
e. Rupture/hernia	○	○
f. Rectal disease, hemorrhoids or blood from the rectum	○	○
g. Skin diseases *(e.g. acne, eczema, psoriasis, etc.)*	○	○
h. Frequent or painful urination	○	○
i. High or low blood sugar	○	○
j. Kidney stone or blood in urine	○	○
k. Sugar or protein in urine	○	○
l. Sexually transmitted disease *(syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)*	○	○
14.a. Adverse reaction to serum, food, insect stings or medicine	○	○
b. Recent unexplained gain or loss of weight	○	○
c. Currently in good health *(If no, explain in Item 29 on Page 2.)*	○	○
d. Tumor, growth, cyst, or cancer	○	○

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
15.a. Dizziness or fainting spells	○	○
b. Frequent or severe headache	○	○
c. A head injury, memory loss or amnesia	○	○
d. Paralysis	○	○
e. Seizures, convulsions, epilepsy or fits	○	○
f. Car, train, sea, or air sickness	○	○
g. A period of unconsciousness or concussion	○	○
h. Meningitis, encephalitis, or other neurological problems	○	○
16.a. Rheumatic fever	○	○
b. Prolonged bleeding *(as after an injury or tooth extraction, etc.)*	○	○
c. Pain or pressure in the chest	○	○
d. Palpitation, pounding heart or abnormal heartbeat	○	○
e. Heart trouble or murmur	○	○
f. High or low blood pressure	○	○
17.a. Nervous trouble of any sort *(anxiety or panic attacks)*	○	○
b. Habitual stammering or stuttering	○	○
c. Loss of memory or amnesia, or neurological symptoms	○	○
d. Frequent trouble sleeping	○	○
e. Received counseling of any type	○	○
f. Depression or excessive worry	○	○
g. Been evaluated or treated for a mental condition	○	○
h. Attempted suicide	○	○
i. Used illegal drugs or abused prescription drugs	○	○
18. FEMALES ONLY. Have you ever had or do you now have:		
a. Treatment for a gynecological (female) disorder	○	○
b. A change of menstrual pattern	○	○
c. Any abnormal PAP smears	○	○
d. First day of last menstrual period *(YYYYMMDD)*		
e. Date of last PAP smear *(YYYYMMDD)*		

	YES	NO
19. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.	○	○
b. Inability to perform certain motions	○	○
c. Inability to stand, sit, kneel, lie down, etc.	○	○
d. Other medical reasons *(If yes, give reasons.)*	○	○
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 had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	○	○
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*	○	○
25. Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)*	○	○
26. Have you ever been discharged from military service for any reason? *(If yes, give date, reason, and type of discharge, whether honorable, other than honorable, for unfitness or unsuitability.)*	○	○
27. 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.)*	○	○
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.)*

"I have no fear of heights, depths, or dark enclosed spaces" _____ (candidate signature)

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

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

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.)*

a. COMMENTS

History of:

-- Head Injury	Yes/No
-- Concussion	Yes/No
-- Amnesia	Yes/No
-- Asthma	Yes/No
-- Recreational Diving	Yes/No
-- DCS/AGE	Yes/No
-- Difficulty clearing ears under water	Yes/No
-- Stitches	Yes/No
-- Broken Bones	Yes/No
-- Joint Surgery	Yes/No
-- ADD/ADHD	Yes/No
-- Depression or Anxiety	Yes/No
-- Smoking	Yes/No
-- Substance Abuse	Yes/No

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*

U. S. MILITARY DIVING MEDICAL SCREENING QUESTIONNAIRE

Supporting Directives MILPERSMAN 1220-100, 1220-200, 1220-300, and 1200-400

PRIVACY ACT STATEMENT

AUTHORITY AND PURPOSE: 5 U.S.C. 301, Departmental Regulations; and E.O. 9397 (SSN). Provided information is to assist officials and employees of the Navy in management, supervision and administration of Navy personnel (officer and enlisted) and the operations of related personnel affairs and functions.

ROUTING USES: Information will be utilized by Department of the Navy Officials in verifying qualifications for NSW/NSO programs.

1. NAME (Last, First, MI)	2. RATE/RANK	3. DOB
4. PRESENT COMMAND	5. BRANCH OF SERVICE	6. DATE

CONCEALMENT OF MEDICAL HISTORY WILL BE REPORTED TO HIGHER AUTHORITIES AND MAY RESULT IN PERMANENT DISQUALIFICATION.

DIVING MEDICAL QUESTIONS:

1. Have you ever been found medically disqualified for a dive physical or any other physical at any time?	○ YES	○ NO
2. Since your last physical, or in the last 18 months, have you been sick, injured, consulted a physician, used medication (including over-the-counter), or been hospitalized for any reason?	○ YES	○ NO
3. Have you ever experienced any middle or inner ear dysfunction including inability to equalize middle ear pressure, inner or middle ear surgery, ringing, disequilibrium, hearing deficit?	○ YES	○ NO
4. Is or has your uncorrected vision ever been worse than 20/20 in either eye?	○ YES	○ NO
5. Do you have any difficulty distinguishing colors or seeing at night?	○ YES	○ NO
6. Have you ever had any corneal surgery, or manipulation to correct poor vision?	○ YES	○ NO
7. Since age 12, have you had asthma or wheezing at any time?	○ YES	○ NO
8. Have you ever had a collapsed lung (pneumothorax), experienced pulmonary barotrauma, had a positive PPD, or taken INH in the past 6 months?	○ YES	○ NO
9. Do you have any skin condition worsened by tight clothing, moisture, or sun exposure?	○ YES	○ NO
10. Do you have any musculoskeletal condition that limits intense exercise, suffered any type of fracture in the last 3 months, or had any bone/joint surgery in the last 6 months?	○ YES	○ NO
11. Have you ever been evaluated for, or treated for, any psychiatric problems (including depression, anxiety, personality disorder, etc.)?.	○ YES	○ NO
12. Have you ever had legal, professional or personal problems due to alcohol use, or been diagnosed with dependence, or had any level of treatment for abuse?	○ YES	○ NO
13. Have you ever had a migraine or other severe headache?	○ YES	○ NO
14. Have you ever had seizures, convulsions or sustained a head injury resulting in loss of consciousness, loss of memory, concussion, or skull fracture?	○ YES	○ NO
15. Have you ever had brain surgery?	○ YES	○ NO
16. Do you have any area of altered sensation or strength in your body?	○ YES	○ NO
17. Have you ever suffered Decompression Sickness or Arterial Gas Embolism?	○ YES	○ NO
18. Do you suffer from motion sickness or fear of enclosed spaces?	○ YES	○ NO

19. PATIENT SIGNATURE	20. DATE

U. S. MILITARY MEDICAL SCREENING QUESTIONNAIRE

ANY POSITIVE RESPONSES REQUIRE ELABORATION ON THIS PAGE BY A DIVING MEDICAL OFFICER

1. NAME (Last, First, MI)	2. RATE/RANK	3. DOB
4. PRESENT COMMAND	5. BRANCH OF SERVICE	6. DATE

ADDITIONAL DIVING MEDICAL QUESTIONS:

UMO SCREEN (to be filled out by UMO, HMO or qualified representative)

1. DD Form 2808, Report of Medical Examination and DD Form 2807-1, Report of Medical History are complete, correct, for dive/jump duty and within 1 year of transfer to training?	○ YES	○ NO
2. Is the physical signed/countersigned by a UMO or HMO?	○ YES	○ NO
3. Every page of member's health record has been reviewed?	○ YES	○ NO
4. Any disqualifying condition has a completed, approved waiver from BUMED (Undersea Medicine and Radiation Health)?	○ YES	○ NO
5. Any non-disqualifying condition that might affect dive training is thoroughly documented?	○ YES	○ NO

UNDERSEA MEDICAL OFFICER COMMENTS

QUESTION #	COMMENT	CD/NCD?		WAIVER?	
		○ YES	○ NO	○ YES	○ NO
		○ YES	○ NO	○ YES	○ NO
		○ YES	○ NO	○ YES	○ NO
		○ YES	○ NO	○ YES	○ NO
		○ YES	○ NO	○ YES	○ NO
		○ YES	○ NO	○ YES	○ NO
		○ YES	○ NO	○ YES	○ NO
		○ YES	○ NO	○ YES	○ NO

6. SIGNATURE	7. STAMP
8. PHONE NUMBER	9. FAX NUMBER

RECORD SCREENING (to be filled in by medical department)

10. G6PD Results	11. Sickle Cell Results	12. Blood Type

IMMUNIZATION MUST BE COMPLETED AND CURRENT PRIOR TO TRANSFER	13. Tetanus	14. Typhoid
	15. Yellow Fever	16. HAV
	17. Flu	

U. S. MILITARY MEDICAL SCREENING QUESTIONNAIRE

UMO SCREEN (to be filled out by UMO, HMO or qualified representative)

1. NAME (Last, First, MI)	2. RATE/RANK	3. DOB
4. PRESENT COMMAND	5. BRANCH OF SERVICE	6. DATE

ADDITIONAL DIVING MEDICAL QUESTIONS (continued)

1. PPD given with diving medical examination.	○ YES	○ NO	2. DATE	3. PPD Converter	○ YES	○ NO

PPD Converters must complete INH Tx prior to transfer to diver training. PPD annual questionnaire required for converters.

4. Date of last Dive Physical (DD 2807-1/2808):	5. Dental, must be Class I or II. Last examination date:
6. Pressure Test, date completed:	

	Completed	
7. NAVMED 6150/2, Special Duty Medical Abstract required signature from UMO/HMO stating Physically Qualified Diving Duty.	○ YES	○ NO
8. The following studies are documented on DD 2808: CXR, EKG, Audiogram, PPD, visual acuity, depth perception, color vision, CBC, urinalysis, and fasting blood glucose?	○ YES	○ NO

11. MEDICAL SCREENER NAME, RANK/RATE, AND TITLE	12. PHONE NUMBER
	13. FAX NUMBER
14. COMMAND'S MAILING ADDRESS	

NOTE: THE U. S. MILITARY DIVING MEDICAL SCREENING QUESTIONNAIRE MUST BE COMPLETED NO LATER THAN 1 MONTH PRIOR TO ACTUAL TRANSFER TO TRAINING AND PLACED IN THE SERVICE MEMBER'S MEDICAL RECORD. ANY WAIVERS MUST HAVE WRITTEN APPROVAL BY BUREAU OF MEDICINE AND SURGERY (BUMED) AND INCLUDED IN THE SERVICE MEMBER'S MEDICAL RECORD.

DIVING STANDARDS AND WAIVERS:
NAVMED P-117, Manual of the Medical Department, chapter 15, article 15-102.

BUMED TELEPHONE: COMM (202)762-3444

NAVMED 6150/2 (Rev. 4-70)
Formerly NAVMED 1346
S/N 0105-LF-209-5021

HEALTH RECORD	SPECIAL DUTY MEDICAL ABSTRACT

SUMMARY OF PHYSICAL EXAMINATIONS FOR SPECIAL DUTY

DATE	PLACE	PURPOSE	RESULT - RECOMMENDATION (Defects-Waivers)	BUMED ACTION	SIG. OF M.O.
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

SUSPENSION FROM SPECIAL DUTY

DATE (From) (To)	NO. OF DAYS	REASON FOR SUSPENSION	SIGNATURE OF MEDICAL OFFICER
1.			
2.			
3.			
4.			
5.			
6.			
7.			

PERIODIC SPECIAL DUTY REQUALIFICATION

DATE	SIGNATURE OF MEDICAL OFFICER	DATE	SIGNATURE OF MEDICAL OFFICER	DATE	SIGNATURE OF MEDICAL OFFICER
1.		7.		13.	
2.		8.		14.	
3.		9.		15.	
4.		10.		16.	
5.		11.		17.	
6.		12.		18.	

NAME (Last) (First) (Middle)	GRADE/RATE	SERVICE/SSN	ORGANIZATION	AGE

ALTITUDE TRAINING, AIR COMPRESSION AND OXYGEN TOLERANCE

DATE	STATION	TYPE OF RUN-REACTION	SIG. OF M.O.
1.			
2.			
3.			
4.			
5.			

EXPLOSIVE DECOMPRESSION TRAINING

DATE	STATION	ALTITUDES-REACTION	SIG. OF M.O.
1.			
2.			

SUBMARINE ESCAPE AND DIVING TRAINING

DATE	STATION	TYPE OF RUN-REACTION	SIG. OF M.O.
1.			
2.			
3.			
4.			
5.			

VISUAL AND DISORIENTATION TRAINING

DATE	STATION	TYPE OF TRAINING	SIG. OF M.O.
1.			
2.			
3.			
4.			

CENTRIFUGE AND EJECTION SEAT TRAINING

DATE	STATION	TYPE OF RUN-REACTION	SIG. OF M.O.
1.			
2.			

REMARKS: