

## MRD Clinic (IDC-only Platforms) Physicals Cover Page

*Located next to Optometry in the 32<sup>nd</sup> St Branch Medical Clinic (in the acute care area) BLDG 3300, ph#: 619-556-8114*

(Must attach to the front of physicals package)

IDC Instructions: *All* of the following must be completed and signed off by you. Please make sure physicals package is dropped off at 32<sup>nd</sup> street MRD clinic **as soon as possible**. IDC Questions: Call Your Physican Supe @ 556-5191

Item #	Purpose (circle <u>all</u> that apply): Separation, retirement, ADMIN SEP, commissioning, SAR, misc/other _____	IDC Initials verifying completion	Date Item was completed (not date signed off by IDC)
<b>Section 1</b>			
<b><i>Specific Requirements for all separation, retirement and ADMIN SEP physicals</i></b>			
1	EAOS _____ Desired Terminal leave start date _____		n/a
2	If ADMIN SEP - Circle Reason: ex. MH, Misconduct, Substance Abuse, BCA Failures, other _____). Date of expected separation: _____		n/a
3	If BCA Failure related Admin Sep, has medical w/u for obesity been completed? Circle: Yes or No (contact your physician supe for w/u if necessary)		
4	Audiogram within one year. If positive TS, follow-up audiogram performed? Y/N		
5	PHA Completed within 1 year. Confirm it is in medical record? Y/N		
6	PPD results or NAVMED 6224/8 form completed. Confirm in med record? Y/N		
7	Optometry evaluation within 2 years if patient wears glasses or contacts		
8	Hepatitis C (Hep C AB) screening within 5 years (required). Non-reactive: Y/N		
9	HIV within 2 years (required)		
10	Does patient request a Reserves Physical? Circle: Yes/No/NA		n/a
11	If female, does pt have WWE complete w/in 1 year? Circle: Yes/No		
12	If female, are there any abnormal PAPs in AHLTA? Circle: Yes/No		
<b>Section 2</b>			
<b><i>General Requirements for all Physicals (sep/ret/admin sep/SAR/commissioning...)</i></b>			
13	Reviewed each line item on the DD 2807, and addressed each "yes" answer separately (described all workup/labs/imaging that were done for each complaint, sx's are documented as improving/stable/worse; status of consults are described, results of labs/imaging/consults are documented).		n/a
14	I have reviewed ALL AHLTA lab studies and documented any abnormal results		
15	I have reviewed ALL AHLTA radiology studies and documented any abnormal results		
16	I have reviewed ALL AHLTA previous encounters and ensured all chronic diagnoses and current treatments are described in detail on the 2807.		
17	I have <u>not</u> signed my name in the medical officer signature blocks		n/a
18	I have read the GUIDANCE on the next page in detail and understand its content.		n/a
19	I have completed this document to the best of my ability and am aware that poor execution may affect both my patient and my monthly/quarterly MRD evaluations.		n/a
20	If this package was sent back for corrections, I have completed all corrections and the 2807 paperwork has been updated with detailed descriptions - all items that were needed (ex. Labs, rad studies, consults, additional explanations by IDC and/or patient) are complete and explanations have been added to the original paperwork.		
21	All pages are included (SF-600, 2807 x3 pg, 2808 x3 pg, 2697 x3 pg, PSD form)		

Patient's Full Name: \_\_\_\_\_

Patient's phone #: \_\_\_\_\_

Ship's Name/Command: \_\_\_\_\_

Ship's/Medical Phone #: \_\_\_\_\_

Patient's Last 4 of SSN: \_\_\_\_\_

Patient's Email: \_\_\_\_\_

IDC's name: \_\_\_\_\_

IDC's Email: \_\_\_\_\_

### **Additional IDC Guidance**

-IDCs: ENSURE YOUR PATIENT COMPLETES THEIR SECTION OF THE 2807 CORRECTLY AND FULLY TO SAVE YOU TIME! (each 'yes' answer needs a description by the patient with: **date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status**).

-IDCs *must* initial and enter the dates of completion on all blocks on this cover page prior to receiving an appointment.

-All blocks that the patient answers yes to on Form 2807 need to be addressed by the IDC on page 2, and must describe the workup performed (ex. imaging/labs/specialty evaluation) and the status of the patient's condition (ex. stable, worsening, improving).

-All conditions for which the patient answers 'yes' that have not been evaluated recently or ever before, and which are not completely resolved, must be evaluated and worked up by the IDC prior to sending the pt to Physicals clinic – at a minimum all pertinent imaging, labs, EKG, specialty consults should be ordered prior to submitting the package.

-YOU are required to check the results of all labs/rad studies that you ordered, and document abnormal results into physicals paperwork.

-IDC's are highly encouraged to email/phone call their physician supervisor for specific guidance on workups as applicable.

- After MRD reviews the package, you will be contacted with a time and date for your patient's appointment only IF the package was completed satisfactorily. If not, you will be contacted with corrective actions needed prior to an appt being scheduled.

-Patients should be seen between **at least 60-90 days prior to EAOS - and can be seen up to 180 days out from EAOS!**

-**No terminal leave should be authorized by your command until completion of the separation physical.**



## 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  
Aug 31, 2014

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, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 1155 Defense Pentagon, Washington, DC 20301-1155 (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 U.S.C. 136, DoD Instruction 6130.03, and E.O. 9397, as amended (SSN).

**PRINCIPAL PURPOSE(S):** The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted on the prescreening form (DD 2807-2). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted. Completed forms are covered by recruiting, medical evaluation board, and official military personnel file SORNs maintained by each of the Services.

**ROUTINE USE(S):** The Blanket Routine Uses found at [http://privacy.defense.gov/blanket\\_uses.shtml](http://privacy.defense.gov/blanket_uses.shtml) apply to this collection.

**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. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.

**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) Naval Branch Health Clinic - Naval Base San Diego, MRD 2450 Craven St. Bldg 3300 San Diego, CA 92104	
b. HOME TELEPHONE (Include Area Code)		

<b>X ALL APPLICABLE BOXES:</b>			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	b. COMPONENT <input type="checkbox"/> Regular <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 (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.

<b>HAVE YOU EVER HAD OR DO YOU NOW HAVE:</b>					
10.a. Tuberculosis	YES	NO	12. (Continued)	YES	NO
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, pollutants, 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
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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:	a. Sensitivity to chemicals, dust, sunlight, etc.	<input type="radio"/>	<input type="radio"/>
b. Frequent or severe headache	<input type="radio"/>	<input type="radio"/>		b. Inability to perform certain motions	<input type="radio"/>	<input type="radio"/>
c. A head injury, memory loss or amnesia	<input type="radio"/>	<input type="radio"/>		c. Inability to stand, sit, kneel, lie down, etc.	<input type="radio"/>	<input type="radio"/>
d. Paralysis	<input type="radio"/>	<input type="radio"/>		d. Other medical reasons (If yes, give reasons.)	<input type="radio"/>	<input type="radio"/>
e. Seizures, convulsions, epilepsy or fits	<input type="radio"/>	<input type="radio"/>		20. Have you ever been treated in an Emergency Room? (If yes, for what?)		
f. Car, train, sea, or air sickness	<input type="radio"/>	<input type="radio"/>		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.)		
g. A period of unconsciousness or concussion	<input type="radio"/>	<input type="radio"/>		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.)		
h. Meningitis, encephalitis, or other neurological problems	<input type="radio"/>	<input type="radio"/>		23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)		
16.a. Rheumatic fever	<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? (If yes, give complete address of doctor, hospital, clinic, and details.)			
b. Prolonged bleeding (as after an injury or tooth extraction, etc.)	<input type="radio"/>	<input type="radio"/>	25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.)			
c. Pain or pressure in the chest	<input type="radio"/>	<input type="radio"/>	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.)			
d. Palpitation, pounding heart or abnormal heartbeat	<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? (If yes, specify what kind, granted by whom, and what amount, when, why.)			
e. Heart trouble or murmur	<input type="radio"/>	<input type="radio"/>	28. Have you ever been denied life insurance?			
f. High or low blood pressure	<input type="radio"/>	<input type="radio"/>				
17.a. Nervous trouble of any sort (anxiety or panic attacks)	<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"/>				
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 (YYYYMMDD)						
e. Date of last PAP smear (YYYYMMDD)						

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					
<p><b>AUTHORITY:</b> PL 103-160, EO 9397.</p> <p><b>PRINCIPAL PURPOSE:</b> 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.</p> <p><b>ROUTINE USES:</b> A copy of this form will be released to the Department of Veterans Affairs.</p> <p><b>DISCLOSURE:</b> Voluntary; however, failure to disclose the requested personal information may result in delay in processing any disability claim.</p>					
<b>SECTION I - TO BE COMPLETED BY SERVICE MEMBER. Any service member who requests a physical examination may have one.</b>					
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**

NBHC - Naval Base San Diego, MRD

**24. DATE OF ASSESSMENT**

*(YYMMDD)*

**25. HEALTH CARE PROVIDER**

a. NAME *(Last, First, Middle Initial)*

b. GRADE/RANK

c. SIGNATURE

<b>REPORT OF MEDICAL EXAMINATION</b>				1. DATE OF EXAMINATION (YYYYMMDD)		2. SOCIAL SECURITY NUMBER		
<b>PRIVACY ACT STATEMENT</b>								
<p><b>AUTHORITY:</b> 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.  <b>PRINCIPAL PURPOSE(S):</b> 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.  <b>ROUTINE USE(S):</b> None.  <b>DISCLOSURE:</b> 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.</p>								
3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)			4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code)			5. HOME TELEPHONE NUMBER (Include Area Code)		
6. GRADE	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	10.a. RACIAL CATEGORY (X one or more) <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		
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 (Aviators Only)			b. TOTAL FLYING TIME		c. LAST SIX MONTHS			
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 (Include ZIP Code) NBHC - Naval Base San Diego, MRD 2450 Craven St. Bldg 3300 San Diego, CA 92104	
<b>CLINICAL EVALUATION</b> (Check each item in appropriate column. Enter "NE" if not evaluated.)								
				Normal	Ab-norm	NE	44. NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)	
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								
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.)				35. FEET (Continued) (Circle category)				
<input type="checkbox"/> Acceptable				Normal Arch	Mild	Asymptomatic		
<input type="checkbox"/> Not Acceptable Class _____				Pes Cavus	Moderate	Symptomatic		
				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			55. MIN WGT - MAX WGT			MAX BF %			56. TEMPERATURE			57. PULSE				
			lbs.																
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 <sup>o</sup>		EX <sup>o</sup>		R.H.		L.H.		Prism div.		Prism Conv		NPR		PD					
										CT									
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		SAT		UNSAT
Right								Right											UNSAT
Left								Left											UNSAT
73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY (Use additional sheets if necessary.)																			



## TUBERCULOSIS EXPOSURE RISK ASSESSMENT

**FOR THE PATIENT** (Including those with previous positive tuberculin skin test)(Check the correct response)

1. Since your last Tuberculosis Exposure Risk Assessment, were you exposed to anyone known to have or suspected of having active tuberculosis (i.e., individuals with persistent cough, weight loss, night sweats, and/or fever)?  Yes  No  Don't Know

2. Since your last Tuberculosis Exposure Risk Assessment or Post-Deployment Health Assessment (DD Form 2796), did you have direct and prolonged contact with any individuals of the following groups: refugees or displaced persons; patients hospitalized with tuberculosis, prisoners, or homeless shelter populations?  Yes  No

3a. Check any countries where you have traveled or deployed to since your last Tuberculosis Exposure Risk Assessment.

- |                                      |                                     |   |                                      |
|--------------------------------------|-------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Bangladesh  | <input type="checkbox"/> Ethiopia   | <input type="checkbox"/> Pakistan           | <input type="checkbox"/> UR Tanzania |
| <input type="checkbox"/> Brazil      | <input type="checkbox"/> India      | <input type="checkbox"/> Philippines        | <input type="checkbox"/> Viet Nam    |
| <input type="checkbox"/> Burma       | <input type="checkbox"/> Indonesia  | <input type="checkbox"/> Russian Federation | <input type="checkbox"/> Zimbabwe    |
| <input type="checkbox"/> Cambodia    | <input type="checkbox"/> Kenya      | <input type="checkbox"/> South Africa       | <input type="checkbox"/> None        |
| <input type="checkbox"/> China       | <input type="checkbox"/> Mozambique | <input type="checkbox"/> Thailand           |                                      |
| <input type="checkbox"/> DR Congo    | <input type="checkbox"/> Nigeria    | <input type="checkbox"/> Uganda             |                                      |
| <input type="checkbox"/> Other _____ |                                     |   |                                      |

If any of these listed countries are selected, answer question 3c.

If "other" is checked, write in the name of the country or countries.

3b. Have you recently traveled to Afghanistan for any reason other than as part of a deployment requiring completion of a Post Deployment Health Assessment (PDHA)?  Yes  No If Yes, go to 3c. Otherwise, go to 4a.

3c. During this travel, did you have prolonged direct contact with the local population? Prolonged direct contact is generally understood as having been within six feet of a person with a bad continuous cough for at least 8 consecutive hours on a single day, or for a total of at least 15 hours per week of a multi-week stay.  Yes  No

4a. Have you recently had a chronic cough lasting more than 2 weeks?  Yes  No

4b. If you marked YES to chronic cough, did you have any of the following at the same time?  
 Fever  Cough up Blood  Unexplained Weight Loss  Night Sweats  
 If any are checked, see the medical officer for evaluation.

### FOR THE SCREENER

1. Questions 1 through 4 reviewed, all responses are negative, no further action is required.  Yes  No

2. There is at least one positive answer, patient to continue to medical officer for assessment.  Yes  No

### FOR THE PROVIDER

(Expand on above answers to document decision making in determining risk)  
 (Note: Prior treated TST reactors require clinical evaluation to rule out active TB, not a repeat TST).

1. Provider Comments

2. Tuberculosis risk assessment, based on above responses (If the answer to one or more of questions 1, 2, 3c, or 4b is a YES, test the patient.)  Minimal Risk  Increased Risk

3. Recommend Latent Tuberculosis Infection (LTBI) Testing  Yes  No

PROVIDER'S NAME

PROVIDER'S SIGNATURE

DATE

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)

HOSPITAL OR MEDICAL FACILITY

STATUS

DEPARTMENT / SERVICE

RECORDS MAINTAINED AT

SPONSOR'S NAME

SSN

RELATIONSHIP TO SPONSOR

**NPPSC SEPARATIONS QUESTIONNAIRE**  
**NPPSC 1900/1 (05-2015)**

Supporting Directive NPPSCINST 1320.1B CH-2

**Privacy Act Statement**

**AUTHORITY:** 10 U.S.C. 5013, Secretary of the Navy.

**PURPOSE:** To provide necessary separation and contact summary information ensuring final administrative actions are taken when a member separates from the Navy.

**ROUTINE USES:** Department of Defense employees executing their duties to assist in an individual's separation from the Navy.

**DISCLOSURE:** Mandatory. Failure to provide the requested information may inhibit the Navy's separation process.

**SERVICE MEMBER INFORMATION**

1. Rate/Rank		2. Name		3. Date of Birth	
4. Cell Phone Number			5. Personal E-mail Address		
6. Type of Separation				7. Separation Date	
8. Dates of Permissive TDY		9. Dates of Terminal Leave		10. Home of Record	
From:	To:	From:	To:	11. Place of Entry on Active Duty	
				12. Home of Selection (if applicable)	
13. Complete Mailing Address after Separation					
Street Address					
City					
State				Zip Code	
14. Name, Relationship, and Complete Mailing Address of Nearest Relative					
Name					
Relationship					
Street Address					
City					
State				Zip Code	
15. Are You in a Loan Repayment Program?			16. If Yes, State Years of Commitment		
17. Request Copy 6 of DD 214 to the State of			18. Request Copy 3 of DD 214 to be sent to the Central Veteran's Affairs Office in Washington DC		

**MEDICAL AND DENTAL ENDORSEMENT**

1. Physically Qualified for Separation		2. Dental Exam Complete?	
3. MTF has Possession of the STR?		4. Requires Additional Dental Treatment?	
5. Name of the Medical Treatment Facility			
6. Name of Medical Officer/Representative			
7. Signature of Medical Officer/Representative			
8. Name of Dental Officer/Representative			
9. Signature of Dental Officer/Representative			

Navy members separating from an activity that are not within an area supported by a Navy Medical Treatment Facility (MTF) or do not have DoD MTF within a reasonable commuting distance, please make copies of your service treatment record and dental record and forward the originals to:

**NAVY MEDICINE RECORDS ACTIVITY (NMRA)**  
**BUMED DETACHMENT ST LOUIS**  
**4300 GOODFELLOW BLVD BLDG 103**  
**ST LOUIS MO 63120**

All service treatment records are the property of the U.S. Government and must be maintained at the appropriate medical/dental facility. The VA cannot process any current or future claim without a complete record on file at the time of separation.

1. Service Member Name		3. CO or Designee Name	
2. Service Member Signature		4. CO or Designee Signature	