

REPORT OF MEDICAL EXAMINATION			1. DATE OF EXAMINATION (YYYYMMDD)		2a. SOCIAL SECURITY NUMBER		2b. DoD ID NUMBER (If applicable)		
PRIVACY ACT STATEMENT									
<p>AUTHORITY: 10 U.S.C. 504, Persons not qualified; 10 U.S.C. 505, Regular components: qualifications, term, grade; 10 U.S.C. 507, Extension of enlistment for members needing medical care or hospitalization; 10 U.S.C. 532, Qualifications for original appointment as a commissioned officer; 10 U.S.C. 978, Drug and alcohol abuse and dependency; testing of new entrants; 10 U.S.C. 1201, Regulars and members on active duty for more than 30 days: retirement; 10 U.S.C. 1202, Regulars and members on active duty for more than 30 days: temporary disability retired list; 10 U.S.C. 4346, Cadets: requirements for admission; DoD Directive 1145.2, United States Military Entrance Processing Command; E.O. 9397 (SSN) and 10 U.S.C. 1204, Members on Active Duty for 30 Days or Less or on Inactive Duty Training: Retirement, as amended.</p> <p>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.</p> <p>ROUTINE USE(S): The Routine Uses are listed in the applicable system of records notice found at: http://dpclid.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/</p> <p>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.</p>									
3. LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)			4. HOME ADDRESS (Street, Apartment Number, City, State and Zip Code)			5a. HOME TELEPHONE NUMBER (Include Area Code)		5b. E-MAIL ADDRESS	
6. GRADE/RANK	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9a. BIRTH SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	9b. PREFERRED GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	10a. ETHNIC CATEGORY <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non Hispanic/Latino		10b. RACIAL CATEGORY (Select one) <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		
11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY b. CIVILIAN		12. AGENCY (Non-Service Members Only)			13. ORGANIZATION UNIT AND UIC/CODE NOAA Aircraft Operations Center UIC/085-74004				
14a. RATING OR SPECIALTY (Aviators Only)			14b. TOTAL FLYING TIME			14c. LAST SIX MONTHS			
15a. SERVICE <input type="checkbox"/> Army NOAA <input type="checkbox"/> Navy PHS <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard		15b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard		15c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Retirement <input type="checkbox"/> Commission <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Retention <input type="checkbox"/> ROTC Scholarship Program <input type="checkbox"/> Separation <input type="checkbox"/> Medical Board <input type="checkbox"/> Other _____			16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include Zip Code)		
MEDICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.)					43. DENTAL DEFECTS AND DISEASE Acceptable <input type="checkbox"/> (Please explain. Use dental form if completed by dentist. If abnormality noted, explain in item 44.) Not Acceptable <input type="checkbox"/> Class _____				
				Normal	Abnormal	NE			
17. Head, face, neck and scalp				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
18. Nose				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
19. Sinuses				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
20. Mouth and throat				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
21. Ears - General (Int. and ext. canals/Auditory acuity under item 71)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
22. Tympanic Membranes (Perforation)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
23. Eyes - General				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
24. Ophthalmoscopic				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
25. Pupils (Equality and reaction)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
26. Ocular motility (Associated parallel movements, nystagmus)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
27. Heart (Thrust, size, rhythm, sounds)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
28. Lungs and chest (Include breasts)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
29. Vascular system (Varicosities, etc.)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
30. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
31. Abdomen and viscera (Include hernia)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
32. External genitalia (Genitourinary)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
33. Upper extremities				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
34. Lower extremities (Except feet)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
35. Feet (Check category)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
35a. <input type="checkbox"/> Normal Arch <input type="checkbox"/> Pes Planus <input type="checkbox"/> Pes Cavus									
35b. <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe									
35c. <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic <input type="checkbox"/> Rigid									
36. Spine, other musculoskeletal				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
37. Body marks, scars, tattoos				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
38. Skin, lymphatics				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
39. Neurologic				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
40. Psychiatric (Specify any personality disorder)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
41. Pelvic (Females only)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
42. Endocrine				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
							44. NOTES: (Mandatory comment for every abnormality identified in items 17 - 43. Enter pertinent item number before each comment. Continue comments or use drawings in item 89 and use additional sheets if necessary.)		

LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)						SOCIAL SECURITY NUMBER				DoD ID NUMBER					
LABORATORY FINDINGS															
45. URINALYSIS			a. Albumin			b. Sugar			46. URINE HCG			47. H/H		48. BLOOD TYPE	
TESTS			RESULTS			HIV SPECIMEN ID LABEL				DRUG TEST SPECIMEN ID LABEL					
49. HIV															
50. DRUGS															
51. ALCOHOL															
52. OTHER															
a. PAP SMEAR															
b. EKG															
c. CXR															
MEASUREMENTS AND OTHER FINDINGS															
53. HEIGHT (in.)		54. WEIGHT (lbs.)		55a. MIN WGT		55b. MAX WGT		55c. MAX BF %		55d. BMI		56. TEMPERATURE		57. HEART RATE	
58. BLOOD PRESSURE						59. RED/GREEN				60. OTHER VISION TEST					
a. 1ST		b. 2ND		c. 3RD											
SYS.		SYS.		SYS.											
DIAS.		DIAS.		DIAS.											
61. DISTANCE VISION				62. REFRACTION				<input type="checkbox"/> AUTO <input type="checkbox"/> MANIFEST <input type="checkbox"/> CYCLO		63. NEAR VISION					
Right Uncorr. 20/		Corr. to 20/		Sph:		Cyl:		Axis:		Right Uncorr. 20/		Corr. to 20/		Add:	
Left Uncorr. 20/		Corr. to 20/		Sph:		Cyl:		Axis:		Left Uncorr. 20/		Corr. to 20/		Add:	
64. HETEROPHORIA															
ES		EX		R.H.		L.H.		Prism div.		Prism Conv CT		NPR		PD	
65. ACCOMMODATION				66. COLOR VISION (Pass/Fail and Score)				67. DEPTH PERCEPTION (Pass/Fail and Score)							
Right		Left		PIP		RED/GREEN		Color Dx		AFVT		RANDOT/MCST			
68. FIELD OF VISION						69. NIGHT VISION						70. INTRAOCULAR PRESSURE			
												O.D.		O.S.	
71a. AUDIOMETER Unit Serial Number						71b. Unit Serial Number						72a. READING ALOUD TEST:		<input type="checkbox"/> SAT <input type="checkbox"/> UNSAT	
Date Calibrated (YYYYMMDD)						Date Calibrated (YYYYMMDD)						72b. VALSALVA:		<input type="checkbox"/> SAT <input type="checkbox"/> UNSAT	
HZ		500		1000		2000		3000		4000		6000		72c. OTHER TESTING	
Left															
Right															
73. NOTES AND/OR INTERVAL HISTORY															

89. ADDITIONAL REMARKS