

CUI (when filled in)

REPORT OF MEDICAL EXAMINATION			1. DATE OF EXAMINATION (YYYYMMDD)		2a. SOCIAL SECURITY NUMBER		2b. DoD ID NUMBER (If applicable)		
<b>PRIVACY ACT STATEMENT</b> <b>AUTHORITY:</b> 10 U.S.C. 504, Persons not qualified; 10 U.S.C. 505, <b>Regular components: qualifications, term, grade;</b> 10 U.S.C. 507, <b>Extension of enlistment for members needing medical care or hospitalization;</b> 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. <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> The Routine Uses are listed in the applicable system of records notice found at: <a href="http://dpclid.defense.gov/Privacy/SORNSIndex/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/">http://dpclid.defense.gov/Privacy/SORNSIndex/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/</a> <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.									
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		9. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		10. RACE AND ETHNICITY (Select All That Apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other	
11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY b. CIVILIAN			12. AGENCY (Non-Service Members Only)			13. ORGANIZATION UNIT AND UIC/CODE			
14a. RATING OR SPECIALTY (Aviators Only)			14b. TOTAL FLYING TIME			14c. LAST SIX MONTHS			
15a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Marine Corps <input type="checkbox"/> Navy <input type="checkbox"/> Coast Guard <input type="checkbox"/> USPHS		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"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> Other <input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program <input type="checkbox"/> Medical Board		16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include Zip Code)			
<b>MEDICAL EVALUATION</b> (Check each item in appropriate column. Enter "NE" if not evaluated.)						43. DENTAL DEFECTS AND DISEASE (Please explain. Use dental form if completed by dentist. If abnormality noted, explain in item 44.)			
						Acceptable <input type="checkbox"/> Not Acceptable <input type="checkbox"/> Class _____			
17. Head, face, neck and scalp						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
18. Nose						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
19. Sinuses						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
20. Mouth and throat						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
21. Ears - General (Int. and ext. canals/Auditory acuity under item 71)						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
22. Tympanic Membranes (Perforation)						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
23. Eyes - General						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
24. Ophthalmoscopic						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
25. Pupils (Equality and reaction)						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
26. Ocular motility (Associated parallel movements, nystagmus)						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
27. Heart (Thrust, size, rhythm, sounds)						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
28. Lungs and chest (Include breasts)						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
29. Vascular system (Varicosities, etc.)						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
30. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
31. Abdomen and viscera (Include hernia)						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
32. External genitalia (Genitourinary)						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
33. Upper extremities						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
34. Lower extremities (Except feet)						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
35. Feet (Check category)						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
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"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
37. Body marks, scars, tattoos						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
38. Skin, lymphatics						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
39. Neurologic						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
40. Psychiatric (Specify any personality disorder)						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
41. Pelvic (Females only)						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
42. Endocrine						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> NE			
						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.)			

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LAST NAME - FIRST NAME - MIDDLE NAME <i>(Suffix)</i>										SOCIAL SECURITY NUMBER					DoD ID NUMBER																
<b>LABORATORY FINDINGS</b>																															
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																															
<b>MEASUREMENTS AND OTHER FINDINGS</b>																															
53. HEIGHT <i>(in.)</i>				54. WEIGHT <i>(lbs.)</i>				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 <i>(Pass/Fail and Score)</i>						67. DEPTH PERCEPTION <i>(Pass/Fail and Score)</i>																			
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		HZ		500		1000		2000		3000		4000		6000		72c. OTHER TESTING			
Left														Left																	
Right														Right																	
73. NOTES AND/OR INTERVAL HISTORY																															

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<b>74. EXAMINEE</b> <input type="checkbox"/> IS MEDICALLY QUALIFIED <input type="checkbox"/> IS NOT MEDICALLY QUALIFIED						75. I have been advised of my disqualifying condition(s).					
						75a. SIGNATURE OF EXAMINEE			75b. DATE (YYYYMMDD)		
<b>76. PHYSICAL PROFILE</b>											
P	U	L	H	E	S	X	D	PROFILER INITIALS		DATE (YYYYMMDD)	
<b>77. SIGNIFICANT OR DISQUALIFYING MEDICAL DIAGNOSES</b>											
ITEM NO.	MEDICAL DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE (YYYYMMDD)	QUALIFIED	DISQUALIFIED	EXAMINER INITIALS	WAIVER RECEIVED			
								SERVICE	DATE (YYYYMMDD)		
<b>78. SUMMARY OF MEDICAL DIAGNOSES</b> <i>(List diagnoses with item numbers) (Use additional sheets if necessary).</i>											
<b>79. RECOMMENDATIONS</b> <i>(Specify) (Use additional sheets if necessary).</i>											
<b>80. MEPS WORKLOAD</b> <i>(For MEPS use only)</i>											
WKID	ST	DATE (YYYYMMDD)	INITIALS			WKID	ST	DATE (YYYYMMDD)	INITIALS		
<b>81. MEDICAL INSPECTION DATE</b>		HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	EXAMINER'S NAME AND SIGNATURE		
<b>82a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER</b>						<b>82b. Signature</b>					
<b>83a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER</b>						<b>83b. Signature</b>					
<b>84a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN</b> <i>(Indicate which)</i>						<b>84b. Signature</b>					
<b>85a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY</b> <i>(Indicate which)</i>						<b>85b. Signature</b>					
<b>86. This examination has been administratively reviewed for completeness and accuracy.</b>											
<b>a. SIGNATURE</b>					<b>b. GRADE</b>				<b>c. DATE (YYYYMMDD)</b>		
<b>87. WAIVER GRANTED</b> <i>(If yes, date and by whom)</i>					YES <input type="checkbox"/>		NO <input type="checkbox"/>		<b>88. NUMBER OF ATTACHED SHEETS</b>		

89. ADDITIONAL REMARKS