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
September, 30 2021

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 the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. 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, Under Secretary Of Defense For Personnel And Readiness; DoD Directive 1145.2, United States Military Entrance Processing Command; DoD Instruction 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services; and E.O. 9397 (SSN), as amended.
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.
ROUTINE USE(S): The Routine Uses are listed in the applicable system of records notice found at: http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/
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.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2.a. SOCIAL SECURITY NO.	b. DoD ID NO. *(If applicable)*	3. TODAY'S DATE *(YYYYMMDD)*
[redacted]	[redacted]	[redacted]	

4.a. HOME ADDRESS *(Street, Apartment No., City, State, and ZIP Code)*
[redacted]

b. HOME TELEPHONE *(Include Area Code)*
[redacted]

c. EMAIL ADDRESS
[redacted]

5. EXAMINING LOCATION AND ADDRESS *(Include ZIP Code)*
Building 6551
6551 Eisenhower Ave.
Fort Knox, KY 40121

X ALL APPLICABLE BOXES:

6.a. SERVICE
- [X] Army
- [ ] Coast Guard
- [ ] Navy
- [ ] Marine Corps
- [ ] Air Force

b. COMPONENT
- [ ] Regular
- [X] Reserve
- [ ] National Guard

c. PURPOSE OF EXAMINATION
- [ ] Retention
- [ ] Separation
- [ ] Medical Board
- [ ] Retirement
- [X] Other *(Specify)*

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

b. USUAL OCCUPATION
Student

8. CURRENT MEDICATIONS *(Prescription and Over-the-counter)*
NONE

9. ALLERGIES *(Including insect bites/stings, foods, medicine or other substance)*
NONE

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	○	●

Prescribed by: DoDI 1304.2

REPORT OF MEDICAL EXAMINATION

1. DATE OF EXAMINATION (YYYYMMDD)	2a. SOCIAL SECURITY NUMBER	2b. DoD ID NUMBER (If applicable)
[redacted]	[redacted]	[redacted]

PRIVACY ACT STATEMENT

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 ac ive 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.
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): The Routine Uses are listed in the applicable system of records notice found at: http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's applica ion 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
[redacted]	[redacted]	[redacted]	[redacted]

6. GRADE/ RANK	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9a. BIRTH SEX	9b. PREFERRED GENDER	10a. ETHNIC CATEGORY	10b. RACIAL CATEGORY (Select one)
CADET	[redacted]	22	☑ Male ☐ Female	☑ Male ☐ Female	☐ Hispanic/Latino ☑ Non Hispanic/Latino	☐ American Indian or Alaska Native ☑ Asian ☐ Black or African American ☐ White ☐ Na ive Hawaiian or Other Pacific Islander

11. TOTAL YEARS GOVERNMENT SERVICE		12. AGENCY (Non-Service Members Only)	13. ORGANIZATION UNIT AND UIC/CODE
a. MILITARY	b. CIVILIAN		USACC UNIV OF MASS W0C705

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

15a. SERVICE	15b. COMPONENT	15c. PURPOSE OF EXAMINATION		16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include Zip Code)
☑ Army ☐ Air Force ☐ Marine Corps ☐ Navy ☐ Coast Guard	☐ Ac ive Duty ☐ Reserve ☐ National Guard	☐ Enlistment ☑ Commission ☐ Retention ☐ Separation ☐ Other	☐ Retirement ☐ U.S. Service Academy ☐ ROTC Scholarship Program ☐ Medical Board	Building 6551 6551 Eisenhower Ave. Fort Knox, KY 40121

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

	Normal	Abnormal	NE
17. Head, face, neck and scalp	☐	☐	☐
18. Nose	☐	☐	☐
19. Sinuses	☐	☐	☐
20. Mouth and hroat	☐	☐	☐
21. Ears - General *(Int. and ext. canals/Auditory acuity under item 71)*	☐	☐	☐
22. Tympanic Membranes *(Perforation)*	☐	☐	☐
23. Eyes - General	☐	☐	☐
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 *(Check category)*	☐	☐	☐
35a. ☐ Normal Arch ☐ Pes Planus ☐ Pes Cavus			
35b. ☐ Mild ☐ Moderate ☐ Severe			
35c. ☐ Asymptomatic ☐ Symptomatic ☐ Rigid			
36. Spine, other musculoskeletal	☐	☐	☐
37. Body marks, scars, tattoos	☐	☐	☐
38. Skin, lympha ics	☐	☐	☐
39. Neurologic	☐	☐	☐
40. Psychiatric *(Specify any personality disorder)*	☐	☐	☐
41. Pelvic *(Females only)*	☐	☐	☐
42. Endocrine	☐	☐	☐

43. DENTAL DEFECTS AND DISEASE *(Please explain. Use dental form if completed by dentist. If abnormality noted, explain in item 44)*

Acceptable ☐
Not Acceptable ☐
Class _____

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)*

Focused Abbreviated Examination performed as clinically indicated IAW AR 40-502. Ch. 6, Para 5, a, (2), to include reviewof DD 2807-1 and required labs. Refer to Cadet's DoDMERB physical for complete exam findings.

LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)	SOCIAL SECURITY NUMBER	DoD ID NUMBER
[redacted]	[redacted]	[redacted]

LABORATORY FINDINGS

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

TESTS	RESULTS
49. HIV	Neg
50. DRUGS	Conducted by USA Cadet Command
51. ALCOHOL	Neg
52. OTHER	
a. PAP SMEAR	
b. EKG	
c. CXR	

HIV SPECIMEN ID LABEL

DRUG TEST SPECIMEN ID LABEL

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 ☐ AUTO ☐ MANIFEST ☐ 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:	☐ SAT ☐ UNSAT
Date Calibrated *(YYYYMMDD)*	Date Calibrated *(YYYYMMDD)*	72b. VALSALVA:	☐ SAT ☐ UNSAT

HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000
Left							Left						
Right							Right						

72c. OTHER TESTING

73. NOTES AND/OR INTERVAL HISTORY

Prescribed by: DoDI 1304.2

LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)	SOCIAL SECURITY NUMBER	DoD ID NUMBER
[redacted]	[redacted]	[redacted]

74. EXAMINEE	75. I have been advised of my disqualifying condition(s).	
[X] IS MEDICALLY QUALIFIED [ ] IS NOT MEDICALLY QUALIFIED	75a. SIGNATURE OF EXAMINEE	75b. DATE *(YYYYMMDD)*

76. PHYSICAL PROFILE

P	U	L	H	E	S	X	D	PROFILER INITIALS	DATE *(YYYYMMDD)*
1	1	1	1	1	1	1	1		

77. SIGNIFICANT OR DISQUALIFYING MEDICAL DIAGNOSES

ITEM NO.	MEDICAL DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE *(YYYYMMDD)*	QUALIFIED	DISQUALIFIED	EXAMINER INITIALS	WAIVER RECEIVED	
								SERVICE	DATE *(YYYYMMDD)*

78. SUMMARY OF MEDICAL DIAGNOSES *(List diagnoses with item numbers) (Use additional sheets if necessary).*
Meets accession standards IAW DODI 6130.03.

79. RECOMMENDATIONS *(Specify) (Use additional sheets if necessary).*
All changes in medical status were reported and any future medical changes between now and commissioning will be reported to Professor of Military Science.

80. MEPS WORKLOAD *(For MEPS use only)*

WKID	ST	DATE *(YYYYMMDD)*	INITIALS	WKID	ST	DATE *(YYYYMMDD)*	INITIALS

81. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	EXAMINER'S NAME AND SIGNATURE

82a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	82b. Signature [redacted]
83a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	83b. Signature
84a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	84b. Signature
85a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY *(Indicate which)*	85b. Signature

86. This examination has been administratively reviewed for completeness and accuracy.

a. SIGNATURE	b. GRADE	c. DATE *(YYYYMMDD)*

87. WAIVER GRANTED *(If yes, date and by whom)*	YES [ ]	NO [ ]	88. NUMBER OF ATTACHED SHEETS