Prescribed by: DoDI 1304.2

# REPORT OF MEDICAL EXAMINATION

| 1. DATE OF EXAMINATION (YYYYMMDD) | 2a. SOCIAL SECURITY NUMBER | 2b. DoD ID NUMBER (If applicable) |
|---|---|---|
| | | |

**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 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.
**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 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 | 9a. BIRTH SEX | 9b. PREFERRED GENDER | 10a. ETHNIC CATEGORY | 10b. RACIAL CATEGORY (Select one) |
|---|---|---|---|---|---|---|
| | | | ☐ Male ☐ Female | ☐ Male ☐ Female | ☐ Hispanic/Latino ☐ Non Hispanic/Latino | ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ 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 |
|---|---|---|---|
| | | | |

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

| 15a. SERVICE | 15b. COMPONENT | 15c. PURPOSE OF EXAMINATION |
|---|---|---|
| ☐ Army ☐ Air Force ☐ Marine Corps ☐ Navy ☐ Coast Guard | ☐ Active Duty ☐ Reserve ☐ National Guard | ☐ Enlistment ☐ Commission ☐ Retention ☐ Separation ☐ Other ☐ Retirement ☐ U.S. Service Academy ☐ ROTC Scholarship Program ☐ Medical Board |

**16. NAME OF EXAMINING LOCATION, AND ADDRESS** *(Include Zip Code)*

Kaehler Memorial Clinic
5201 Lee Road
Buzzards Bay, MA 02542

**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 throat | ☐ | ☐ | ☐ |
| **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, lymphatics | ☐ | ☐ | ☐ |
| **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.)*

AA:

SBT:

Valsalva:

| 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 ☐ 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 10052651 | 71b. Unit Serial Number | 72a. READING ALOUD TEST: ☐ SAT ☐ UNSAT |
|---|---|---|
| Date Calibrated *(YYYYMMDD)* 20200507 | 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**

FBS: _____

Total Cholesterol:_____

HDL: _____

LDL: _____

Triglycerides:_____

RPR:_____

If H/H is out of range-
RBC: Males 4.3 - 6.2 million, Females 3.8 - 5.4 million
MCV: 82 - 92 cubic microns
MCH: 27 - 32 picograms
MCHC: 30 - 32%

| LAST NAME - FIRST NAME - MIDDLE NAME (Suffix) | SOCIAL SECURITY NUMBER | DoD ID NUMBER |
|---|---|---|
| | | |

| 74. EXAMINEE | 75. I have been advised of my disqualifying condition(s). | |
|---|---|---|
| ☐ IS MEDICALLY QUALIFIED<br>☐ 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)* |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

**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).*

**79. RECOMMENDATIONS** *(Specify) (Use additional sheets if necessary).*

**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 |
|---|---|
| | |
| **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 |
|---|---|---|---|
| | | | |

**89. ADDITIONAL REMARKS**