Prescribed by: DoDI 1304.2 1. DATE OF EXAMINATION 2a. SOCIAL SECURITY NUMBER 2b. DoD ID NUMBER REPORT OF MEDICAL EXAMINATION (YYYYMMDD) (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 4. HOME ADDRESS (Street, Apartment Number, City, 5a. HOME TELEPHONE 3. LAST NAME - FIRST NAME - MIDDLE NAME 5b. E-MAIL ADDRESS State and Zip Code) NUMBER (Include Area Code) (Suffix) 6. GRADE/ 7. DATE OF BIRTH 8. AGE 9a. BIRTH SEX 9b. PREFERRED GENDER 10a. ETHNIC CATEGORY 10b. RACIAL CATEGORY (Select one) RANK (YYYYMMDD) American Indian or Alaska Native Asian Male Male Hispanic/Latino Black or African American White Non Hispanic/Latino Female **IFemale** Native Hawaiian or Other Pacific Islander 11. TOTAL YEARS GOVERNMENT SERVICE 12. AGENCY (Non-Service Members Only) 13. ORGANIZATION UNIT AND UIC/CODE a MII ITΔRY b CIVII IAN 14a. RATING OR SPECIALTY (Aviators Only) 14c. LAST SIX MONTHS 14b. TOTAL FLYING TIME 15a. SERVICE 15b. COMPONENT 15c. PURPOSE OF EXAMINATION 16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include Zip Code) Enlistment Retirement Army Active Duty Commission U.S. Service Academy Air Force Reserve Retention **ROTC Scholarship Program** National Guard Marine Corps Separation Medical Board Navy Other Coast Guard 43. DENTAL DEFECTS AND DISEASE MEDICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.) Acceptable (Please explain. Use dental form if Normal Abnormal NE completed by dentist. If abnormality noted, Not Acceptable 17. Head, face, neck and scalp explain in item 44.) Class **18.** Nose 19. Sinuses 44. NOTES: (Mandatory comment for every abnormality identified in items 17 - 43. Enter pertinent item number before each comment. 20. Mouth and throat Continue comments or use drawings in item 89 and use additional 21. Ears - General (Int. and ext. canals/Auditory acuity under item 71) sheets if necessary.) 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) Upper extremities 34. Lower extremities (Except feet) 35. Feet (Check category) Pes Planus Pes Cavus Normal Arch 35a. 35b 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

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LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)				SOCIAL SECURITY NUMBER					Dod ID NUMBER											
							LABO	RATO	RY FIN	DINGS										
45. URINALYSIS a. Albumin		min	b. Sugar				46. URINE HCG 47. H/H				H/H	48. BLOOD TYPE								
TESTS					RESU	LTS			HIV SI	PECIME	N ID LA	BEL		DRU	IG TE	ST SP	ECIN	/IEN ID	LABE	_
49. HIV																				
50. DRUGS									1											
51. ALCOHOL 52. OTHER									1											
a. PAP SMEAR									-											
b. EKG									1											
c. CXR									1											
						MEA	SUREME	NTS A	⊥ ND OTI	HER FIN	DINGS									
53. HEIGHT (in.)	54. WEI	GHT (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.	DIAS.														
61. DISTANCE VISION	N	•		62. REF	RACTIC	ON _	AUTO	MA	NIFEST	CY	CLO	63. NE	AR VISION	•						
Right Uncorr. 20/			Sph:		Cyl:			Axis:		Right l	ght Uncorr.		Corr. to 20/			Add:				
Left Uncorr. 20/			Sph:		Cyl:			Axis:			Left Ui	eft Uncorr.		Corr. to 20/			Add:			
64. HETEROPHORIA				•						•		•								
ES EX R.H		R.H.		L.H.	L.H. Pris					OT NPR				PD						
65. ACCOMMODATIO	N		66	6. COLO	R VISIO	N (Pass/F	ail and Sco	ore)				67. DE	PTH PERCE	PTIO	N (Pas	ss/Fail a	and S	core)		
Right Left PIP				RED/ GREEN			Color Dx AFV			AFVT	T RANDOT/ MCST									
68. FIELD OF VISION						T VISION				70. INTRAOCULAR PRESSURE										
										O.D. O.S.										
71a. AUDIOMETER Unit Serial Number				71b. Unit	Serial Nur					72a. READ ALOUD TE				SAT		UN	SAT			
Date Calibrated (YYYYMMDD)				Date Cal	brated (Y)	OD)				72b. VALSALVA	۸:			SAT		UN	SAT			
HZ 500	1000 2	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000	72c. OTHE		STING	3				
						Left							_							
Left						5							1							
Left Right						Right														

Prescribed by: DoDI 1304.2 DoD ID NUMBER LAST NAME - FIRST NAME - MIDDLE NAME (Suffix) SOCIAL SECURITY NUMBER 74. EXAMINEE 75. I have been advised of my disqualifying condition(s). IS MEDICALLY QUALIFIED 75a. SIGNATURE OF EXAMINEE 75b. DATE (YYYYMMDD) IS NOT MEDICALLY QUALIFIED 76. PHYSICAL PROFILE Р L Н Е s Х D PROFILER INITIALS | DATE (YYYYMMDD) 77. SIGNIFICANT OR DISQUALIFYING MEDICAL DIAGNOSES WAIVER RECEIVED ITEM **RBJ DATE** ICD CODE PROFILE SERIAL QUALIFIED DISQUALIFIED EXAMINER INITIALS MEDICAL DIAGNOSIS NO. (YYYYMMDD) 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 DATE (YYYYMMDD) INITIALS EXAMINER'S NAME AND SIGNATURE 81. MEDICAL INSPECTION DATE HT WT %BF MAX WT **HCG QUAL** DISQ 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) 88. NUMBER OF NO YES ATTACHED SHEETS

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89. ADDITIONAL REMARKS		