# Marine Corps Forces Special Operations Command
# SO/DIVE PE (A&S/ITC Candidates)
# POC: adam.cannon.ctr@socom.mil

**Patient's Name:** _____ **SSN Last Four:** _____

Member must complete the following and have physical completed and signed by MO/PA before getting an appointment for UMO undersign. Medical exam must be completed before test results expire.

**Reference: MANMED 15-5, 15-102, 15-105, AR 40-501 (8-12)**

☐ DD 2807-1 ☐ DD 2808 ☐ NAVMED 6150/2 (Special Duty Abstract) ☐ NAVMED 6244/8 (LTBI)

Within 3 months prior to the exam date the following must be accomplished (unless otherwise specified)

**RADIOLOGY:** Results Expire in 90 Days of NSW Exam Date
- ☐ CXR (PA/LAT)
- ☐ EKG (Include Signed copy by Examining Physician/PA)

**AUDIOGRAM:**
- ☐ Audiogram (within 12 months)
- ☐ Valsalva (provider only)

**DENTAL:** Results Expire in 90 Days of NSW Exam Date
- ☐ Dental T-2 Exam results on DD 2808

**OPTOMETRY:** Results Expire in 90 Days of NSW Exam Date
- ☐ Visual Acuity (if worse than 20/20, refraction)
- ☐ Color Vision (ISHIHARA/PIP)
- ☐ Depth Perception (randot x/9, xsec of arc)

**Laboratory:** Results Expire in 90 Days of NSW Exam Date
- ☐ PPD current LTBI screening within 6 months
- ☐ CBC (WBC, PLT, HGB, HCT)
- ☐ Fasting Blood Sugar (FBS)
- ☐ Urinalysis (Spec grav, blood, albumin, sugar, LE, nit)
- ☐ UA Micro (WBC/RBC) (Must be **microscopic** and dipstick)

**Additional Laboratory**:
- ☐ HIV (As Per DoD Inst. 6485.01) (within 2 yrs)
- ☐ HEP C (within 5 yrs)
- ☐ Blood Type (only once in career) documented
- ☐ Sickle Cell (only once in career) documented
- ☐ G6PD (only once in career) documented

- ☐ All Immunizations up to date

# 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



**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)* |
|---|---|---|---|
| | | | |

| 4.a. HOME ADDRESS *(Street, Apartment No., City, State, and ZIP Code)* | 5. EXAMINING LOCATION AND ADDRESS *(Include ZIP Code)* |
|---|---|
| | |

**b. HOME TELEPHONE** *(Include Area Code)*

**c. EMAIL ADDRESS**

**X ALL APPLICABLE BOXES:**

**6.a. SERVICE**

- [ ] Army
- [ ] Coast Guard
- [ ] Navy
- [X] Marine Corps
- [ ] Air Force

**b. COMPONENT**

- [X] Regular
- [ ] Reserve
- [ ] National Guard

**c. PURPOSE OF EXAMINATION**

- [ ] Retention
- [ ] Separation
- [ ] Medical Board
- [ ] Retirement
- [X] Other *(Specify)*: SO/DIVE

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

**b. USUAL OCCUPATION**

| 8. CURRENT MEDICATIONS *(Prescription and Over-the-counter)* | 9. ALLERGIES *(Including insect bites/stings, foods, medicine or other substance)* |
|---|---|
| | |

**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 | ○ | ○ |

| LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) | SOCIAL SECURITY NUMBER | DoD ID NUMBER *(If applicable)* |
|---|---|---|
| | | |

**Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.**

| HAVE YOU EVER HAD OR DO YOU NOW HAVE: | YES | NO |
|---|---|---|
| 15.a. Dizziness or fainting spells | ○ | ○ |
| b. Frequent or severe headache | ○ | ○ |
| c. A head injury, memory loss or amnesia | ○ | ○ |
| d. Paralysis | ○ | ○ |
| e. Seizures, convulsions, epilepsy or fits | ○ | ○ |
| f. Car, train, sea, or air sickness | ○ | ○ |
| g. A period of unconsciousness or concussion | ○ | ○ |
| h. Meningitis, encephalitis, or other neurological problems | ○ | ○ |
| 16.a. Rheumatic fever | ○ | ○ |
| b. Prolonged bleeding *(as after an injury or tooth extraction, etc.)* | ○ | ○ |
| c. Pain or pressure in the chest | ○ | ○ |
| d. Palpitation, pounding heart or abnormal heartbeat | ○ | ○ |
| e. Heart trouble or murmur | ○ | ○ |
| f. High or low blood pressure | ○ | ○ |
| 17.a. Nervous trouble of any sort *(anxiety or panic attacks)* | ○ | ○ |
| b. Habitual stammering or stuttering | ○ | ○ |
| c. Loss of memory or amnesia, or neurological symptoms | ○ | ○ |
| d. Frequent trouble sleeping | ○ | ○ |
| e. Received counseling of any type | ○ | ○ |
| f. Depression or excessive worry | ○ | ○ |
| g. Been evaluated or treated for a mental condition | ○ | ○ |
| h. Attempted suicide | ○ | ○ |
| i. Used illegal drugs or abused prescription drugs | ○ | ○ |
| **18. FEMALES ONLY.** Have you ever had or do you now have: | | |
| a. Treatment for a gynecological (female) disorder | ○ | ○ |
| b. A change of menstrual pattern | ○ | ○ |
| c. Any abnormal PAP smears | ○ | ○ |
| d. First day of last menstrual period *(YYYYMMDD)* | | |
| e. Date of last PAP smear *(YYYYMMDD)* | | |

| | YES | NO |
|---|---|---|
| **19.** Have you been refused employment or been unable to hold a job or stay in school because of: | | |
| a. Sensitivity to chemicals, dust, sunlight, etc. | ○ | ○ |
| b. Inability to perform certain motions | ○ | ○ |
| c. Inability to stand, sit, kneel, lie down, etc. | ○ | ○ |
| d. Other medical reasons *(If yes, give reasons.)* | ○ | ○ |
| **20.** Have you ever been treated in an Emergency Room? *(If yes, for what?)* | ○ | ○ |
| **21.** Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)* | ○ | ○ |
| **22.** Have you ever had, or have you been advised to have any operations or surgery? *(If yes, describe and give age at which occurred.)* | ○ | ○ |
| **23.** Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) | ○ | ○ |
| **24.** Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)* | ○ | ○ |
| **25.** Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)* | ○ | ○ |
| **26.** Have you ever been discharged from military service for any reason? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)* | ○ | ○ |
| **27.** Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? *(If yes, specify what kind, granted by whom, and what amount, when, why.)* | ○ | ○ |
| **28.** Have you ever been denied life insurance? | ○ | ○ |

**29. EXPLANATION OF "YES" ANSWER(S)** *(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)*

**NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."**

| LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) | SOCIAL SECURITY NUMBER | DoD ID NUMBER *(If applicable)* |
|---|---|---|
| | | |

**30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA** *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

**a. COMMENTS**

MARSOC A&S/SO/DIVE Specific:
YES / NO History of any dive related injury (DCS/AGE/ subcutaneous or mediastinal emphysema/ other barotrauma)
YES / NO History of suicidal/homicidal ideations, gestures or attempts
YES / NO History of anxiety/depression
YES / NO History of alcohol diagnosis
YES / NO History of pneumothorax (spontaneous or traumatic)
YES / NO History of concussion (note any post traumatic amnesia and LOC)
YES / NO History of motion sickness
YES / NO History of heat related injury

In addition to information listed above, I have screened the ____electronic and/or ____paper medical record and found:
____No disqualifying conditions.
____Possible disqualifying condition(s) that will require further study/follow up. Waiver submission may be necessary.
____Disqualifying condition(s) that will require waiver or disqualification submission.

| b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)* | c. SIGNATURE | d. DATE SIGNED *(YYYYMMDD)* |
|---|---|---|
| | | |

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 | | 12. AGENCY (Non-Service Members Only) | 13. ORGANIZATION UNIT AND UIC/CODE |
|---|---|---|---|
| a. MILITARY | b. CIVILIAN | | |
| | | | |

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

| 15a. SERVICE | 15b. COMPONENT | 15c. PURPOSE OF EXAMINATION | 16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include Zip Code) |
|---|---|---|---|
| ☐ Army<br>☐ Air Force<br>☒ Marine Corps<br>☐ Navy<br>☐ Coast Guard | ☒ Active Duty<br>☐ Reserve<br>☐ National Guard | ☐ Enlistment ☐ Retirement<br>☐ Commission ☐ U.S. Service Academy<br>☐ Retention ☐ ROTC Scholarship Program<br>☐ Separation ☐ Medical Board<br>☒ Other SO/DIVE | |

**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.)*

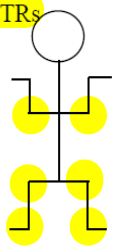
#32: Circ / Testes Hernia

#37: Tattoos/scars:

#38: Skin cancer screen: Pos / Neg

#39 in detail: Mental Status: A&O: __/3 Recall: __/3
Serial 7s: __/5

DTRs



CN II-XII:

CEREBELLUM:
Finger-to-nose:
Heel-to-shin:
RAM:
Romberg:
Tandem Gait:

BABINSKI: POS / NEG

MOTOR:

SENSORY:

#72b. Valsalva SAT / UNSAT

Note: The neurologic exam must be fully documented, with deep tendon reflexes noted on a standard stick figure.
DTR's: Biceps, Triceps, Patella, Achillies
Numerical grading scale (+ 1 - 4)

| 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. PPD | | | |
| 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. PULSE |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| 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 BY ☐ AUTO OR ☐ MANIFEST | | | 63. NEAR VISION | | |
|---|---|---|---|---|---|---|---|
| Left Uncorr. 20/ | Corr. to 20/ | Sph: | Cyl: | Axis: | Left Uncorr. 20/ | Corr. to 20/ | Add: |
| Right Uncorr. 20/ | Corr. to 20/ | Sph: | Cyl: | Axis: | Right 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 *(Test and score/result)* | | | 67. DEPTH PERCEPTION *(Test and score/result)* | |
|---|---|---|---|---|---|---|
| Right | Left | PIP ☐ ____ | FALANT ☐ ____ | 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 |
|---|---|---|---|---|---|---|
| Left | | | | | | |
| Right | | | | | | |

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

**72c. OTHER TESTING**

**73. NOTES AND/OR INTERVAL HISTORY**

CBC DATE:
WBC
HGB
HCT
PLT

DATE:
FBG:

DATE:
G6PD
SICKLE CELL

DATE:
HEP C

DATE:
HIV

DATE:
UA
SG:
PROTEIN
GLUCOSE

UA Micro
DATE:
WBC
RBC

DATE: EXAM#:
CXR INTERPRETATION:

DATE
EKG RESULT:

LTBI SCREENING
WITH IN 6 MONTHS
DATE:

Prescribed by: DoDI 1304.2

| 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)*<br>(UMO's ONLY) | **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**

# TUBERCULOSIS EXPOSURE RISK ASSESSMENT

**FOR THE PATIENT** *(Including those with previous positive tuberculin skin test)(Check the correct response)*

1. Since your last Tuberculosis Exposure Risk Assessment, were you exposed to anyone known to have or suspected of having active tuberculosis (i.e., individuals with persistent cough, weight loss, night sweats, and/or fever)? ☐ Yes ☐ No ☐ Don't Know

2. Since your last Tuberculosis Exposure Risk Assessment or Post-Deployment Health Assessment (DD Form 2796), did you have direct and prolonged contact with any individuals of the following groups: refugees or displaced persons; patients hospitalized with tuberculosis , prisoners, or homeless shelter populations? ☐ Yes ☐ No

3a. Check any countries where you have traveled or deployed to since your last Tuberculosis Exposure Risk Assessment.

| | | | |
|---|---|---|---|
| ☐ Bangladesh | ☐ Ethiopia | ☐ Pakistan | ☐ UR Tanzania |
| ☐ Brazil | ☐ India | ☐ Philippines | ☐ Viet Nam |
| ☐ Burma | ☐ Indonesia | ☐ Russian Federation | ☐ Zimbabwe |
| ☐ Cambodia | ☐ Kenya | ☐ South Africa | ☐ None |
| ☐ China | ☐ Mozambique | ☐ Thailand | |
| ☐ DR Congo | ☐ Nigeria | ☐ Uganda | |

If any of these listed countries are selected, answer question 3c.

☐ Other _____ If "other" is checked, write in the name of the country or countries.

3b. Have you recently traveled to Afghanistan for any reason other than as part of a deployment requiring completion of a Post Deployment Health Assessment (PDHA)? ☐ Yes ☐ No If Yes, go to 3c. Otherwise, go to 4a.

3c. During this travel, did you have prolonged direct contact with the local population? Prolonged direct contact is generally understood as having been within six feet of a person with a bad continuous cough for at least 8 consecutive hours on a single day, or for a total of at least 15 hours per week of a multi-week stay. ☐ Yes ☐ No

4a. Have you recently had a chronic cough lasting more than 2 weeks? ☐ Yes ☐ No

4b. If you marked YES to chronic cough, did you have any of the following at the same time?

☐ Fever ☐ Cough up Blood ☐ Unexplained Weight Loss ☐ Night Sweats

If any are checked, see the medical officer for evaluation.

**FOR THE SCREENER**

1. Questions 1 through 4 reviewed, all responses are negative, no further action is required. ☐ Yes ☐ No

2. There is at least one positive answer, patient to continue to medical officer for assessment. ☐ Yes ☐ No

**FOR THE PROVIDER**

*(Expand on above answers to document decision making in determining risk)*

*(Note: Prior treated TST reactors require clinical evaluation to rule out active TB, not a repeat TST).*

1. Provider Comments

2. Tuberculosis risk assessment, based on above responses
*(If the answer to one or more of questions 1, 2, 3c, or 4b is a YES, test the patient.)* ☐ Minimal Risk ☐ Increased Risk

3. Recommend Latent Tuberculosis Infection (LTBI) Testing ☐ Yes ☐ No

| | | |
|---|---|---|
| PROVIDER'S NAME | PROVIDER'S SIGNATURE | DATE |
| PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)* | HOSPITAL OR MEDICAL FACILITY | STATUS |
| | DEPARTMENT / SERVICE | RECORDS MAINTAINED AT |
| | SPONSOR'S NAME | SSN |
| | RELATIONSHIP TO SPONSOR | |

NAVMED 6150/2 (Rev. 4-70)
Formerly NAVMED 1346
S/N 0105-LF-209-5021

HEALTH RECORD

# SPECIAL DUTY MEDICAL ABSTRACT

**SUMMARY OF PHYSICAL EXAMINATIONS FOR SPECIAL DUTY**

| DATE | PLACE | PURPOSE | RESULT - RECOMMENDATION (Defects-Waivers) | BUMED ACTION | SIG. OF M.O. |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |

**SUSPENSION FROM SPECIAL DUTY**

| DATE (From) (To) | NO. OF DAYS | REASON FOR SUSPENSION | SIGNATURE OF MEDICAL OFFICER |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |

**PERIODIC SPECIAL DUTY REQUALIFICATION**

| DATE | SIGNATURE OF MEDICAL OFFICER | DATE | SIGNATURE OF MEDICAL OFFICER | DATE | SIGNATURE OF MEDICAL OFFICER |
|---|---|---|---|---|---|
| 1. | | 7. | | 13. | |
| 2. | | 8. | | 14. | |
| 3. | | 9. | | 15. | |
| 4. | | 10. | | 16. | |
| 5. | | 11. | | 17. | |
| 6. | | 12. | | 18. | |

| NAME (Last) (First) (Middle) | GRADE/RATE | SERVICE/SSN | ORGANIZATION | AGE |
|---|---|---|---|---|
| | | | | |

## ALTITUDE TRAINING, AIR COMPRESSION AND OXYGEN TOLERANCE

| DATE | STATION | TYPE OF RUN-REACTION | SIG. OF M.O. |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

## EXPLOSIVE DECOMPRESSION TRAINING

| DATE | STATION | ALTITUDES-REACTION | SIG. OF M.O. |
|---|---|---|---|
| 1. | | | |
| 2. | | | |

## SUBMARINE ESCAPE AND DIVING TRAINING

| DATE | STATION | TYPE OF RUN-REACTION | SIG. OF M.O. |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

## VISUAL AND DISORIENTATION TRAINING

| DATE | STATION | TYPE OF TRAINING | SIG. OF M.O. |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

## CENTRIFUGE AND EJECTION SEAT TRAINING

| DATE | STATION | TYPE OF RUN-REACTION | SIG. OF M.O. |
|---|---|---|---|
| 1. | | | |
| 2. | | | |

REMARKS: