# SUBMARINE/NFD/COMMISSIONING PHYSICAL EXAMS

**Patient's Name:** ______________________ **Last Four SSN:** ____________
**Cell Phone #:** ______________________ **DoD Number:** ____________

**Submarine Duty / Nuclear Field Duty*(NFD)* / Commissioning*(Comm)* (Circle Exams Needed)**
**(All studies must be within 3 months of PE unless otherwise noted)**

**References: MANMED 15-5, 15-30:61, 15-103, 15-104, 15-105, 15-106. NSTC M-1533.2C CH-2**

**FORMS:**

- [ ] DD 2807-1 (OCT2018)
- [ ] DD 2808 (JUL2019)
- [ ] NAVMED 6150/2 (APR1970)
- [ ] NAVMED 6470/13 (NFD Only)
- [ ] LTBI screening (NAVMED 6224/8, Within 6 months)

**LAB TESTS / IMAGING / IMMUNIZATIONS**

- [ ] CXR (PA/LAT) (Comm/Sub candidates only)
- [ ] EKG (Comm Only)
- [ ] Sickle Cell, G6PD, Blood Type (only once in career)
- [ ] HIV (As Per DoD Inst. 6485.01, every 2 years)
- [ ] CBC (Comm/NFD Only)
- [ ] UA (Comm/NFD Only)
- [ ] CMP (Comm Only)
- [ ] PPD (Candidates only AND if does NOT have in MRRS)

**Additional Documented Immunities Required for Commissioning:**

- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] MMR
- [ ] Polio
- [ ] Meningococcal
- [ ] Varicella
- [ ] Tdap
- [ ] Influenza

**ADDITIONAL PREREQUISITE EXAMS:**

- [ ] Dental T-2 Exam results on DD 2808 signed by Dentist.
- [ ] Audiogram (Within 1 year)
- [ ] Visual Acuity (if worse than 20/20, refraction required)
- [ ] Color Vision (per MANMED Article 15-36 (1)(d))

**All *FEMALES* must complete the following *IN ADDITION* to the above:**

- [ ] NAVMED 6420/2 (JAN2010) (Sub Only)

- [ ] PAP Smear within the last 36 months if over age 21. (If within 36 months, may transcribe results)
- [ ] Mammogram within the last 12 months starting at age 40 or if at high risk.

***YOU*** are Responsible for bringing this packet to your appointment.
If forgotten you ***WILL*** be rescheduled, No Exceptions.

**Appointment Date/Time:** ______________________

**MRRS Phone #:** **(360) 315-4319 / 4352**

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

| 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 | b. COMPONENT | c. PURPOSE OF EXAMINATION | 7.a. POSITION *(Title, Grade, Component)* |
|---|---|---|---|
| ☐ Army ☐ Coast Guard | ☐ Regular | | |
| ☐ Navy | ☐ Reserve | | b. USUAL OCCUPATION |
| ☐ Marine Corps | ☐ National Guard | | |
| ☐ Air Force | | | |

| 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**

For SUB/NFD:

Do you have any anxiety working in tight or closed spaces? YES/NO    History of Suicidal Behavior? YES/NO
Anxiety working with nuclear power or nuclear weapons? YES/NO    History of Homicidal Behavior? YES/NO
Difficulty working with other personnel? YES/NO    Provider: Explain any/all YES answers below, with Waiver date(s)

| 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**
- ☐ Male
- ☐ Female

**9b. PREFERRED GENDER**
- ☐ Male
- ☐ Female

**10a. ETHNIC CATEGORY**
- ☐ Hispanic/Latino
- ☐ Non Hispanic/Latino

**10b. RACIAL CATEGORY** *(Select one)*
- ☐ 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**
- ☐ Army
- ☐ Air Force
- ☐ Marine Corps
- ☐ Navy
- ☐ Coast Guard

**15b. COMPONENT**
- ☐ Active Duty
- ☐ Reserve
- ☐ National Guard
- ☐ Civilian

**15c. PURPOSE OF EXAMINATION**
- ☐ Enlistment
- ☐ Commission
- ☐ Separation
- ☐ Retirement
- ☐ Submarine
- ☐ Nuclear Field Duty
- ☐ Dive
- ☐ NSW/SO
- ☐ Other ______

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

**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 or 89.)*
- 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.)*

Prescribed by: DoDI 1304.2

| 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 AND/OR DATE | HIV SPECIMEN ID LABEL | DRUG TEST SPECIMEN ID LABEL |
|---|---|---|---|
| 49. HIV | | | |
| 50. G6PD/SICKLE CELL | / | | |
| 51. ALCOHOL/DRUGS | | | |
| 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. PULSE |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| 58. BLOOD PRESSURE | | | 59. RED/GREEN *(Army Only)* | 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 | HZ | 500 | 1000 | 2000 | 3000 | 4000 | 6000 | 72c. OTHER TESTING |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Left | | | | | | | Left | | | | | | | |
| Right | | | | | | | Right | | | | | | | |

73. NOTES AND/OR INTERVAL HISTORY

| 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**

# 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 ☐ Minimal Risk ☐ Increased Risk
*(If the answer to one or more of questions 1, 2, 3c, or 4b is a YES, test the patient.)*

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.)*

NAME:
SSN:
DOB:
RANK/GRADE:

| HOSPITAL OR MEDICAL FACILITY | STATUS |
|---|---|
| DEPARTMENT / SERVICE | RECORDS MAINTAINED AT |
| SPONSOR'S NAME | SSN |
| RELATIONSHIP TO SPONSOR | |