RE	PORT OF	MED	ICAL EX	AM	INATIO	ON				DF EXAMINATION (MMDD)	I	2. SOCIAL	2. SOCIAL SECURITY NUMBER				
						PRI	STA	TEMENT									
PRINCIPAL I applicants a the Armed F ROUTINE US DISCLOSUR individual's	PURPOSE(S): nd members Forces. SE(S): None. E: Voluntary	To ol of the v; how o enter	otain medi Armed Fo ever, failur the Arme	cald rces. reby	lata for o . The in an appl	01, 120 determir formatic icant to	2, and nation on wil provi	d 434 of m I also ide th	l6; an ledica be u	nd E.O. 9397. al fitness for enl used for medical ormation may re	boards and s esult in delay	separation of or possible	intment and retention for of Service members from rejection of the may result in the individual				
3. LAST NAME - FIRST NAME - MIDDLE NAME 4. HOME ADD (SUFFIX)									et, Ap	artment Number,	City, State and	I ZIP Code)	5. HOME TELEPHONE NUMBER (Include Area Code)				
6. GRADE	7. DATE OF		8. AGE 9.		Am		ACIAL CATEGOF nerican Indian or aska Native			Y (X one or more) Black or Africa American	n Native	Hawaiian or Pacific Islander	b. ETHNIC CATEGORY Hispanic/Latino				
SERVICE	11. TOTAL YEARS GOVERNMENT 12. AGENCY (Non-Service Memb						ian ers Oi	nly)		White	13. ORGAN	Not Hispanic/ Latino					
14.a. RATING OR SPECIALTY (Aviators Only) b. TOTAL FLYING								E			c. LAST SIX MONTHS						
Air Forc	Army Coast Guard Active Duty Enlistment							Med Retir U.S.	ical B emen Servi		(Include	DF EXAMININ @ ZIP Code)	NG LOCATION, AND ADDRESS				
CLINICAL E	VALUATION	(Check	k each item	in ap	propriate	column.	Enter	"NE" Ab-	if no	t evaluated.)			detail. Enter pertinent item				
 17. Head, face, neck, and scalp 18. Nose 19. Sinuses 20. Mouth and throat 21. Ears - General (<i>Int. and ext. canals/Auditory acuity under item 71</i> 22. Drums (<i>Perforation</i>) 23. Eyes - General (<i>Visual acuity and refraction under items 61 - 63</i>) 24. Ophthalmoscopic 25. Pupils (<i>Equality and reaction</i>) 26. Ocular motility (<i>Associated parallel movements, nystagmus</i>) 27. Heart (<i>Thrust, size, rhythm, sounds</i>) 28. Lungs and chest (<i>Include breasts</i>) 29. Vascular system (<i>Varicosities, etc.</i>) 										number berg		ent. Continui	e in item 73 and use additional				
 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 (See Item 35 Continued)																	
 36. Spine, other musculoskeletal 37. Identifying body marks, scars, tattoos 38. Skin, lymphatics 																	
39. Neurologi	ality deviet	or)															
40. Psychiatri 41. Pelvic <i>(Fe</i>	ic (Specify any males only)	person	unty ueviali	511)													
42. Endocrine 43. DENTAL DEFECTS AND DISEASE (Please explain. Use dental for by dentist. If dental examinati dental officer, explain in Item 4 Acceptable by dentist. If dental examinati dental officer, explain in Item 4 Not Acceptable Class										35. FEET (Contr Normal Arc Pes Cavus Pes Planus		<i>ategory)</i> Mild Modera Severe	Asymptomatic te Symptomatic				

45. URINALYS	Y FINDINGS																
		a. Al	Albumin 46. URINE HC					47. H/H				48.	BLOO	D TYPE			
			ugar														
TESTS		-	ULTS					HIV SPE	CIMEN I	D LABEL		DRU	G TES	t speci	MEN	ID LABE	
19. HIV												DRUG TEST SPECIMEN ID LABEI					
50. DRUGS																	
51. ALCOHOL																	
52. OTHER																	
a. PAP SMEAR																	
b.																	
с.																	
					MEA	SUREMENT	S AND O	THER FI	NDINGS								
53. Height	54. WEIGHT	55. I	MIN WGT	- MAX V	VGT		MAX BF	%		56. TEMPERATUR		RE 5	57. PU	LSE			
	lbs																
58. BLOOD PRI	ESSURE					59. RED/GRE	(Only)	nly) 60. OTHER VISIO					N TEST				
n. 1ST	b. 2ND	c. 3RD															
SYS.	SYS.		SYS.														
DIAS.	DIAS.		DIAS.														
61. DISTANT V	/ISION		e	62. REFF	RACTIO	N BY AUTOR	EFRACTIC	ON OR MA	NIFEST	63. NEA	R VISION	N					
ight 20/	Corr. to 2	20/	F	Зу	S.	CX				Right 20	Corr. to	rr. to 20/ by					
eft 20/	Corr. to 2			Зу	S.	CX			Left 20/ Corr. to 20/ by								
ES [°] 55. ACCOMMO	ORIA (Specify of EX [°]	н.	L.H. Prism div. 66. COLOR VISION (Test used and resu					Prism CT 67. D		CEPTION	l (Test u	NPR PD					
Right	Left			PIP			/14		Uncorrected				Cor	rected			
68. FIELD OF V	/ISION		I		69. NI	GHT VISION (l and score	and score) 70. INTRA 0.D.			ULAR TENSION 0.S.						
71a. AUDIOME	TER Unit Seri	al Num	ber			71b . Un		0.5			72a. READING ALOUD			LOUD			
	ated (YYYYMM							YYYMMDD)						TEST			
1	500 1000	2000	3000	4000	600		500	1000	2000	3000	4000	6000		SAT		UNSA	
						Right							_	. VALS			
Right						5											

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)													SOCIAL SECURITY NUMBER						
74.a.	EXAMIN	EE/APPLICANT	(check	one)			l have he	en advi	sed of I	wing condition									
											b. I have been advised of my disqualifying condition. . SIGNATURE OF EXAMINEE b. DATE								
		UALIFIED FOR S		CE															
b. PH	YSICAL P	ROFILE																	
	Р		Н	E	E		S		Х	PROFILER	INITIALS	DATE (YYYYMMDD)							
L																			
	GNIFICAN	IT OR DISQUAL	IFYING	G DEFECT	S						1		1						
ITEM NO.	ME	;	ICD PROFILE CODE SERIAL				RBJ DATE (YYYYMMDD)	QUALI- FIED	DIS- QUALI-	EXAMINER INITIALS									
						CODE	-	2111712	,,,,	, , , , , , , , , , , , , , , , , , , ,		FIED		SERV	ICE DI	ATE (YYYYMMDD)			
77. S		OF DEFECTS A	ND DI	AGNOSE	S (List d	iagnoses w	ith item	numbe	ers) (Us	e addition	al sheets	if neces	sary.)						
78. R	ECOMME	NDATIONS - FU	RTHEF	R SPECIA	LIST EX	ΑΜΙΝΑΤΙΟΙ	NS INDIO	ATED	(Speci	fy) (Use ad	dditional	sheets ii	[¢] necessary.)						
70.14			500																
79. IV		RKLOAD (For M	ST	se only)		000000000000000000000000000000000000000		ITIAL	1	WKID			CT.						
	WKID		51		DATE	DATE (YYYYMMDD)				WKID			51	ST DATE (1		D) INITIAL			
80. M	IEDICAL I	NSPECTION DA	TE	HT	WT	%BF	MAX W	т н	ICG	QUAL	DISC		PH	SICIAN'S	S SIGNATURE				
						70 D.				UUAL DISC				0.00 0					
81.a. [*]	TYPED OI	R PRINTED NAM	ne of	PHYSICIA	AN OR EX	XAMINER				b. SIGNATURE									
82.a.	82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER											b. SIGNATURE							
83.a.	83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)											b. SIGNATURE							
84.a.	TYPED OI	R PRINTED NAM	IE OF	REVIEWI	NG OFFI	CER/APPRC	VING A	UTHOF	RITY	b. SIGNATURE									
85. T	his exan	nination has b	een a	dministra	atively I	reviewed	for com	pleten	iess ai	nd accura	acy.								
	GNATUF							b. GRADE c. DATE (YYYYMMDD)											
<u> </u>	/AIVER GI YES	RANTED (If yes,	. date .	and by w	hom)								<u> </u>		87. NUM ATT	BER OF ACHED SHEETS			
	NO																		