

<b>REPORT OF MEDICAL EXAMINATION</b>				<b>1. DATE OF EXAMINATION</b> (YYYYMMDD) 20080214		<b>2. SOCIAL SECURITY NUMBER</b> Passport #	
<b>PRIVACY ACT STATEMENT</b>							
<p>AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4316.</p> <p>PRINCIPAL PURPOSE(S): To obtain medical data for applicants and members of the Armed Forces, the Armed Forces.</p> <p>ROUTINE USE(S): None.</p> <p>DISCLOSURE: Voluntary; however, failure of individual's application to enter the Armed Forces, or failure to provide the information may result in the individual being placed in a non-deployable status.</p>							
<b>3. LAST NAME - FIRST NAME - MIDDLE NAME</b> (SUFFIX) SMITH, JOHN H				<b>4. HOME ADDRESS</b> (Street, Apartment Number, City, State and ZIP Code) 156 CHEVROLET AVE BERLIN, GERMANY			<b>5. HOME TELEPHONE NUMBER</b> (Include Area Code) N/A
<b>6. GRADE</b> MAJ	<b>7. DATE OF BIRTH</b> (YYYYMMDD) 19540102	<b>8. AGE</b> 54	<b>9. SEX</b> <input type="checkbox"/> Female <input checked="" type="checkbox"/> Male	<b>10.a. RACIAL CATEGORY</b> (X one or more) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian			<b>b. ETHNIC CATEGORY</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino
<b>11. TOTAL YEARS GOVERNMENT SERVICE</b> a. MILITARY b. CIVILIAN		<b>12. AGENCY</b> (Non-Service Members Only)			<b>13. ORGANIZATION UNIT AND UIC/CODE</b>		
<b>14.a. RATING OR SPECIALTY</b> (Aviators Only)			<b>b. TOTAL FLYING TIME</b>		<b>c. LAST SIX MONTHS</b>		
<b>15.a. SERVICE</b> <input checked="" type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force		<b>b. COMPONENT</b> <input checked="" type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard		<b>c. PURPOSE OF EXAMINATION</b> <input type="checkbox"/> Enlistment <input type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> Medical Board <input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program <input checked="" type="checkbox"/> Other			<b>16. NAME OF EXAMINING LOCATION, AND ADDRESS</b> (Include ZIP Code) MILITARY HOSPITAL #14 BERLIN, GERMANY
<b>CLINICAL EVALUATION</b> (Check each item in appropriate column. Enter "NE" if not evaluated.)							
				Nor- mal	Ab- norm	NE	<b>44. NOTES:</b> (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)  ITEM #37, TATTOO "MOM" ON UPPER LEFT ARM
17. Head, face, neck, and scalp				<input checked="" type="checkbox"/>			
18. Nose				<input checked="" type="checkbox"/>			
19. Sinuses				<input checked="" type="checkbox"/>			
20. Mouth and throat				<input checked="" type="checkbox"/>			
21. Ears - General (Int. and ext. canals/Auditory acuity under item 71)				<input checked="" type="checkbox"/>			
22. Drums (Perforation)				<input checked="" type="checkbox"/>			
23. Eyes - General (Visual acuity and refraction under items 61 - 63)				<input checked="" type="checkbox"/>			
24. Ophthalmoscopic				<input checked="" type="checkbox"/>			
25. Pupils (Equality and reaction)				<input checked="" type="checkbox"/>			
26. Ocular motility (Associated parallel movements, nystagmus)				<input checked="" type="checkbox"/>			
27. Heart (Thrust, size, rhythm, sounds)				<input checked="" type="checkbox"/>			
28. Lungs and chest (Include breasts)				<input checked="" type="checkbox"/>			
29. Vascular system (Varicosities, etc.)				<input checked="" type="checkbox"/>			
30. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)				<input checked="" type="checkbox"/>			
31. Abdomen and viscera (Include hernia)				<input checked="" type="checkbox"/>			
32. External genitalia (Genitourinary)				<input checked="" type="checkbox"/>			
33. Upper extremities				<input checked="" type="checkbox"/>			
34. Lower extremities (Except feet)				<input checked="" type="checkbox"/>			
35. Feet (See Item 35 Continued)				<input checked="" type="checkbox"/>			
36. Spine, other musculoskeletal				<input checked="" type="checkbox"/>			
37. Identifying body marks, scars, tattoos				<input checked="" type="checkbox"/>			
38. Skin, lymphatics				<input checked="" type="checkbox"/>			
39. Neurologic				<input checked="" type="checkbox"/>			
40. Psychiatric (Specify any personality deviation)				<input checked="" type="checkbox"/>			
41. Pelvic (Females only)				<input checked="" type="checkbox"/>			
42. Endocrine				<input checked="" type="checkbox"/>			
<b>43. DENTAL DEFECTS AND DISEASE</b> (Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in Item 44.)							
<input checked="" type="checkbox"/> Acceptable							
<input type="checkbox"/> Not Acceptable Class _____							
							<b>35. FEET</b> (Continued) (Circle category) Normal Arch Mild Asymptomatic Pes Cavus Moderate Pes Planus Severe Symptomatic

All exams require areas in YELLOW highlights

Areas with PINK highlights are required for Aviation students only

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX) SMITH, JOHN H						SOCIAL SECURITY NUMBER PASSPORT #										
LABORATORY FINDINGS																
45. URINALYSIS			a. Albumin			46. URINE HCG			47. H/H			48. BLOOD TYPE 0+				
			b. Sugar													
TESTS			RESULTS						HIV SPECIMEN ID LABEL			DRUG TEST SPECIMEN ID LABEL				
49. HIV			NEGATIVE													
50. DRUGS			NEGATIVE													
51. ALCOHOL			NEGATIVE													
52. OTHER																
a. PAP SMEAR																
b. CHEST XRAY			NEGATIVE													
c.																
MEASUREMENTS AND OTHER FINDINGS																
53. HEIGHT 72		54. WEIGHT 220 lbs.		55. MIN WGT - MAX WGT MAX BF %				56. TEMPERATURE		57. PULSE 71						
58. BLOOD PRESSURE				59. RED/GREEN (Army Only)				60. OTHER VISION TEST								
a. 1ST		b. 2ND		c. 3RD												
SYS. 80		SYS.		SYS.												
DIAS. 112		DIAS.		DIAS.												
61. DISTANT VISION				62. REFRACTION BY AUTOREFRACTION OR MANIFEST				63. NEAR VISION								
Right 20/ 20		Corr. to 20/		By S. CX		Right 20/ 20		Corr. to 20/		by						
Left 20/ 20		Corr. to 20/		By S. CX		Left 20/ 20		Corr. to 20/		by						
64. HETEROPHORIA (Specify distance)																
ES°		EX°		R.H.		L.H.		Prism div.		Prism Conv CT		NPR		PD		
65. ACCOMMODATION				66. COLOR VISION (Test used and result)				67. DEPTH PERCEPTION (Test used and score) AFVT								
Right		Left		PIP /14				Uncorrected		Corrected						
68. FIELD OF VISION				69. NIGHT VISION (Test used and score)				70. INTRAOCULAR TENSION								
								O.D.		O.S.						
71a. AUDIOMETER			Unit Serial Number				71b. Unit Serial Number			72a. READING ALOUD TEST						
Date Calibrated (YYYYMMDD)							Date Calibrated (YYYYMMDD)					TEST				
HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000	SAT	UNSAT	
Right	X	X	X	X	X	X	Right							72b. VALSALVA	SAT	UNSAT
Left	X	X	X	X	X	X	Left									
73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY (Use additional sheets if necessary.)																

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX) SMITH, JOHN H						SOCIAL SECURITY NUMBER PASSPORT #			
74.a. EXAMINEE/APPLICANT (check one)				75. I have been advised of my disqualifying condition.					
<input checked="" type="checkbox"/> IS QUALIFIED FOR SERVICE				a. SIGNATURE OF EXAMINEE			b. DATE (YYYYMMDD) 20080214		
<input type="checkbox"/> IS NOT QUALIFIED FOR SERVICE									
b. PHYSICAL PROFILE									
P	U	L	H	E	S	X	PROFILER INITIALS	DATE (YYYYMMDD)	
76. SIGNIFICANT OR DISQUALIFYING DEFECTS									
ITEM NO.	MEDICAL CONDITION/DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE (YYYYMMDD)	QUALIFIED	DISQUALIFIED	EXAMINER INITIALS	WAIVER RECEIVED	
								SERVICE	DATE (YYYYMMDD)
77. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers) (Use additional sheets if necessary.)									
78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify) (Use additional sheets if necessary.)									
79. MEPS WORKLOAD (For MEPS use only)									
WKID	ST	DATE (YYYYMMDD)	INITIAL	WKID	ST	DATE (YYYYMMDD)	INITIAL		
80. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	PHYSICIAN'S SIGNATURE	
81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER WALTER REED, COL MC				b. SIGNATURE Walter Reed MD					
82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER				b. SIGNATURE					
83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which) JOHN CUDDY, MAJ, DENTIST				b. SIGNATURE John Cuddy DC					
84.a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY				b. SIGNATURE					
85. This examination has been administratively reviewed for completeness and accuracy.									
a. SIGNATURE				b. GRADE			c. DATE (YYYYMMDD)		
86. WAIVER GRANTED (If yes, date and by whom)								87. NUMBER OF ATTACHED SHEETS	
<input type="checkbox"/> YES									
<input type="checkbox"/> NO									