NAVY MEDICAL READINESS & TRAINING UNIT
OPERATIONAL MEDICINE DEPARTMENT
FRONT DESK PHONE NUMBER: 757-953-3778
1550 TOMCAT BLVD SUITE 150, VIRGINIA BEACH VA 23460

PHYSICAL FOR COMMISSIONING

RANK/NAME: _____

PHONE NUMBER: _____

TODAY'S DATE: _____

THIS SECTION FOR OPERATIONAL MEDICINE STAFF

- ☐ Dental signature (Must be signed before medical screening.)
- ☐ PHA Date: _____ ☐ RPR: _____
- ☐ HIV Blood Draw Date: _____ ☐ CBC: _____
- ☐ Chest X-Ray Date: _____ ☐ CMP: _____
- ☐ EKG Date: _____
- ☐ Lipid Test: _____
- ☐ Glucose Test: _____
- ☐ UA w/ Micro: _____
- ☐ HCG Pregnancy Test: _____
- ☐ PAP Exam: _____

Outstanding Requirements:

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 20241031

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 from (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 t he 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 *(Stress, Apartment No., City, State, and ZIP Code)*

b. HOME TELEPHONE *(Include Area Code)*

c. EMAIL ADDRESS

5. EXAMINING LOCATION AND ADDRESS *(Include Zip Code)*

OPERATIONAL MEDICINE DEPARTMENT
NAVY MEDICAL READINESS & TRAINING UNIT
1550 TOMCAT BLVD SUITE 150
NAVAL AIR STATION OCEANA
VIRGINIA BEACH, VA 23460 - 2188
(757) 953 - 3778

X ALL APPLICABLE BOXES:

6.a. SERVICE
- ☐ Army
- ☐ Navy
- ☐ Marine Corps
- ☐ Air Force
- ☐ Coast Guard

b. COMPONENT
- ☐ Regular
- ☐ Reserve
- ☐ National Guard

c. PURPOSE OF EXAMINATION
- ☐ Retention
- ☐ Separation
- ☐ Medical Board
- ☐ Retirement
- ☐ Other *(Specify)*

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 or 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 of 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 NUSE, 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

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
☐ Army ☐ Air Force ☐ Marine Corps ☐ Navy ☐ Coast Guard	☐ Active Duty ☐ Reserve ☐ National Guard	☐ Enlistment ☐ Retirement ☐ Commission ☐ U.S. Service Academy ☐ Retention ☐ ROTC Scholarship Program ☐ Separation ☐ Medical Board ☐ Other _____

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

OPERATIONAL MEDICINE DEPARTMENT
NAVY MEDICAL READINESS & TRAINING UNIT
1550 TOMCAT BLVD SUITE 150
NAVAL AIR STATION OCEANA
VIRGINIA BEACH, VA 23460 - 2188
(757) 953 - 3778

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.)*

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. 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. HEART RATE

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 ☐ AUTO ☐ MANIFEST ☐ CYCLO			63. NEAR VISION		
Right Uncorr. 20/	Corr. to 20/	Sph:	Cyl:	Axis:	Right Uncorr. 20/	Corr. to 20/	Add:
Left Uncorr. 20/	Corr. to 20/	Sph:	Cyl:	Axis:	Left 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 *(Pass/Fail and Score)*			67. DEPTH PERCEPTION *(Pass/Fail and Score)*	
Right	Left	PIP	RED/ GREEN	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
Left							Left						
Right							Right						

72c. OTHER TESTING

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 ☐ 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