

OCCUPATIONAL HEALTH SCREENING FORM

Reason for Visit:

Date:

Patient Information				
Name	DOB	DoD ID or Full SSN:		
Organization/Program		Job Title & Job Series		
Work Number		Cell Number:		
Email:	Supervisor:	Supervisor's Phone:		
Personal medical history (check all that apply)				
☐ No known medical conditions ☐ Allergies (Drug, Food, Environmental) ☐ Anemia ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Autoimmune Disorder (Specify: _____) ☐ Cancer (Specify: _____) ☐ Congestive heart failure ☐ COPD / Emphysema ☐ Depression ☐ Diabetes (Type 1 / Type 2) ☐ Epilepsy / Seizures ☐ GERD (Acid Reflux) ☐ Glaucoma ☐ Gout ☐ Heart Attack / Heart Disease ☐ High Blood Pressure (Hypertension) ☐ High Cholesterol ☐ HIV/AIDS ☐ Kidney Disease / Kidney Stones ☐ Liver Disease / Hepatitis ☐ Migraines ☐ Osteoporosis ☐ Sleep Apnea ☐ Sleep: Insomnia/Difficulties ☐ Stroke ☐ Substance Abuse (Alcohol / Drugs) ☐ Thyroid Disease (Hypo / Hyper) ☐ Tuberculosis ☐ Ulcers				
Other medical issues:				
Medications				
Name(s)	Dosage(s)	Frequency	Reason for Taking	Note(s)
Medication Allergies/Reaction Name of Medication(s): ☐ No medication allergies Reaction(s):				
Allergy to Latex: Yes ☐ No ☐ If yes, reaction:				

Surgeries (site and date)

Social history

Factor	Check one	Most recent date <i>(if applicable)</i>
Tobacco Use	☐ Cigarettes ☐ Cigars ☐ Chew/Dip ☐ Vape ☐ Quit ☐ Never Used	
Alcohol Use	☐ Occasional ☐ Moderate ☐ Heavy ☐ Don't Drink	
Caffeine (Coffee, Tea, Soda, Energy Drinks)	☐ No ☐ Yes (amount per day)	
Pre/Post Workout Supplements	☐ No ☐ Yes [] Times per week	
Exercise Routine	[] Times per week	
Sleep	[] Hours a night	

Living Situation: ☐ With roommates ☐ With S/O ☐ With family ☐ Other:

Additional Notes

By providing my name (full name: first and last), date of birth (DOB) and today's date, I hereby certify that, to the best of my knowledge, the above provided information is true and accurate.

Patient name: _____ DOB: _____ Date: _____

Date:

31. If 2.41

Staff Section:

Vitals:

Height: _____ Weight: _____ BMI: _____

BP: _____ HR: _____ Resp: _____ Temp: _____ O2Sat: _____

Repeat vitals:

Nurses Notes:

Providers Notes:

Staff Section:

Vitals:

Height: _____ Weight: _____ BMI: _____

BP: _____ HR: _____ Resp: _____ Temp: _____ O2Sat: _____

Repeat vitals:

Nurses Notes:

Providers Notes:

Staff Section:

Vitals:

Height: _____ Weight: _____ BMI: _____

BP: _____ HR: _____ Resp: _____ Temp: _____ O2Sat: _____

Repeat vitals:

Nurses Notes:

Providers Notes:

Staff Section:

Vitals:

Height: _____ Weight: _____ BMI: _____

BP: _____ HR: _____ Resp: _____ Temp: _____ O2Sat: _____

Repeat vitals:

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Staff Section:

Vitals:

Height: _____ Weight: _____ BMI: _____

BP: _____ HR: _____ Resp: _____ Temp: _____ O2Sat: _____

Repeat vitals:

Nurses Notes:

Providers Notes:

Staff Section:

Vitals:

Height: _____ Weight: _____ BMI: _____

BP: _____ HR: _____ Resp: _____ Temp: _____ O2Sat: _____

Repeat vitals:

Nurses Notes:

Providers Notes:

PERIODIC TUBERCULOSIS (TB) RISK ASSESSMENT TOOL

For use of this form see, MEDCOM Reg 40-64, the proponent agency is MCPO-SA

Periodic Tuberculosis (TB) Risk Assessment Tool		REVIEWER INSTRUCTION
1. Since your last TB risk assessment, did you have face-to-face contact with someone who was sick with tuberculosis (TB)? If yes, nature of exposure: Household – Co-worker – Family - Other _____ Dates of exposure _____	☐ Yes ☐ No	
2. Since your last TB risk assessment, did you work, volunteer, or reside in a detainee facility, prison, homeless shelter, refugee camp, or drug treatment facility?	☐ Yes ☐ No	
3. Since your last TB risk assessment, did you develop any of the following conditions: organ transplant; HIV Infection; Immunosuppression secondary to use of prednisone (equivalent of >15mg/day for >1 month) or other Immunosuppressive medication such as Humira, Enbrel or Remicade?	☐ Yes ☐ No	
4. Since your last TB risk assessment, did you develop any of the following conditions: diabetes, silicosis, cancer of head or neck, Hodgkin's disease, leukemia, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight [10% or more below ideal weight], or injection drug use?	☐ Yes ☐ No	
All "NO" answers = low risk → <u>STOP</u>. Any "YES" answers = increase risk → <u>Go to question #5</u>		If all "NO" responses → Do NOT test for TB
5. Do you have any of the following symptoms of tuberculosis: cough >2 weeks, fever >2 weeks, drenching night sweats, or unplanned weight loss?	☐ Yes ☐ No	
If "NO" → Go to question #6. If "YES" → STOP		If "YES" then refer immediately to provider for evaluation of TB disease
6. Have you had a prior TB test, prior diagnosis of TB, or prior treatment for TB?	☐ Yes ☐ No <u>STOP.</u>	
Reviewer comments 		If "NO" → Test for TB. If "YES" → Do NOT test, REFER for provider evaluation.
PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last-first-middle; DOB; SSN; date; hospital or medical facility) NAME: DOB: DoD ID #: DATE:	REVIEWER NAME	REVIEWER SIGNATURE

Fox Army Health Center

MCXW-OH

Hearing Program Questionnaire									
Last name			First name			DOB			
SSN			Phone			Rank/Grade			
MOS/Job code			Unit						
Branch/DoD (choose one)									
	Army		Navy		Coast Guard		Air Force		
	Marines		Cadet/ROTC		Civilian		Foreign National		
Service Component (choose one)									
	Active Duty			National Guard			Reserves		
Reason for Hearing Test (choose one)									
	Annual		Pre-employment		Pre-deployment		Retirement/ETS		
	Flight class		PCMH referral		Other:				
Are you bothered by ringing in the ears?									
	Not bothered at all			Bothered a little			Bothered a lot		
What type of hearing protection do you use?									
Do you wear hearing aids?									
Have you been exposed to loud noise within the last 14 hours?									
Have you returned from a deployment in the past 6 months?									
Any history of blast noise exposure?									
Any history of hearing loss?									
Have you seen an audiologist recently?									
Date of audiology appointment:									

Routine Immunization Screening Form: Adult

NOTE: If cholera or smallpox vaccines are being considered, please complete their respective immunization screening forms.

AUTHORITY:	10 U.S.C. 1071-1085, Medical and Dental Care; Army Regulation 40-562, Immunizations and Chemoprophylaxis for the Prevention of Infectious Disease; DoDM 6025.18, Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs.
PURPOSE:	To determine whether you can safely receive a routine immunization.
ROUTINE USES:	Use and disclosure of your records outside of DoD may occur in accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Collected information may be shared with entities including the Departments of Health and Human Services, Veterans Affairs, and other Federal, State, local, or foreign government agencies, or authorized private business entities. To appropriate agencies, entities, and persons when (1) the DoD suspects or has confirmed that there has been a breach of the system of records; (2) the DoD has determined that as a result of the suspected or confirmed breach there is a risk of harm to individuals, the DoD (including its information systems, programs, and operations), the Federal Government, or national security; and (3) the disclosure made to such agencies, entities, and persons is reasonably necessary to assist in connection with the DoD's efforts to respond to the suspected or confirmed breach or to prevent, minimize, or remedy such harm.
APPLICABLE SORN:	EDHA 07, Military Health Information System (November 18, 2013, 78 FR 69076) https://dpcld.defense.gov/Privacy/SORNSIndex/DOD-wide-SORN-Article-View/Article/570672/edha-07/
DISCLOSURE:	Voluntary. If you choose not to provide the requested information, no penalty may be imposed; however, failure to provide the information may result in delays in assessing contraindications for receiving vaccinations.

Patient name:

DOB (YYYYMMDD):

Screening Checklist for Contraindications to Vaccines for Adults

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

		Yes	No	Don't Know
1.	Are you sick today?	☐	☐	☐
2.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
3.	Do you have allergies to medication, food, a vaccine component, or latex?	☐	☐	☐
4.	Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
5.	Have you had a health problem involving heart, lung (e.g., asthma), kidney, or metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☐	☐
6.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
7.	In the past 3 months, have you taken medications that weaken your immune system, such as prednisone or other steroids; anticancer drugs; biologic drugs for autoimmune diseases such as rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
8.	In the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9.	Have you had (or are you a candidate for) your spleen removed, or do you have sickle cell anemia?	☐	☐	☐
10.	Have you ever passed out (had vasovagal syncope) during or after a previous immunization or blood draw?	☐	☐	☐
11.	Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
12.	Are you pregnant or is there a chance you could become pregnant during the next month?	Not Applicable ☐	☐	☐

Please list any medications you are currently taking:

Form completed by:

Date (YYYYMMDD):

Form reviewed by:

Date (YYYYMMDD):

Did you bring your immunization record/card with you?

Yes ☐ No ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it. For questions or concerns regarding immunizations, providers, nurses and patients may call the DHA Immunization Healthcare Support Center 24/7 at 1-877-438-8222, Option 1.

Information for Healthcare Professionals about the Screening Checklist for Contraindications (Adult)

Each screening question is explained in more detail below. For more information, please consult the sources referenced at the end.

1. Are you sick today? [all vaccines]

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events.¹ However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as otitis media, upper respiratory infections, and diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. Have you ever had a serious reaction after receiving a vaccination? [all vaccines]

History of anaphylactic reaction (see question 3) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses.¹ History of encephalopathy within 7 days following DTP/DTaP is a contraindication for further doses of pertussis-containing vaccine. There are other adverse events that may occur following vaccination that constitute contraindications or precautions to future doses. Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

3. Do you have allergies to medications, food, a vaccine component, or latex? [all vaccines]

An anaphylactic reaction to latex is a contraindication to vaccines that contain latex as a component or as part of the packaging (e.g., vial stoppers, prefilled syringe plungers or caps). If a person has anaphylaxis after eating gelatin, do not administer vaccines containing gelatin. For patients with known Alpha-gal syndrome (red meat allergy), caution should be exercised with gelatin-containing vaccines (i.e. MMR, VAR, YF-Vax), as some of these patients have demonstrated anaphylaxis with these vaccines. A local reaction to a prior vaccine dose or vaccine component, including latex, is not a contraindication to a subsequent dose or vaccine containing that component.^{2,3} People with egg allergy of any severity can receive any recommended influenza vaccine (i.e., any IIV or RIV) that is otherwise appropriate for the patient's age. For people with a history of severe allergic reaction to egg involving any symptom other than hives (e.g., angioedema, respiratory distress), or who required epinephrine or another emergency medical intervention, the vaccine should be administered in a medical setting, such as a clinic, health department, or physician's office. Vaccine administration should be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions.⁴

4. Have you had a seizure, or had brain or other nervous system problems?

[IIV, LAIV, Td, Tdap]

Tdap is contraindicated in patients who have a history of encephalopathy within 7 days following DTP/DTaP given as a child. An unstable, progressive neurologic condition is a precaution to the use of Tdap. For patients with stable neurologic disorders (including seizures) unrelated to vaccination, or for patients with a family history of seizures, vaccinate as usual. A history of Guillain-Barre syndrome (GBS) is a precaution for the following: 1) Td/Tdap: if GBS occurred within 6 weeks of a tetanus-containing vaccine and the decision is made to continue vaccination, if no history of prior Tdap, give Tdap instead of Td; 2) Influenza vaccine (IIV or LAIV): if GBS occurred within 6 weeks of a prior influenza vaccination, vaccinate with IIV if at high risk for severe influenza complications.

5. Have you had a health problem involving heart, lung (e.g., asthma), kidney, or metabolic disease (e.g., diabetes), anemia, or other blood disorder? [MMR, LAIV, SPV]

A history of thrombocytopenia or thrombocytopenic purpura is a precaution to MMR vaccine. The safety of LAIV in patients with these conditions has not been established. These conditions, including asthma in adults, should be considered precautions for LAIV use.

6. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?

[Adenovirus, Cholera, LAIV, MMR, SPV, Ty21a, VAR, YF-Vax, ZVL]

Live virus vaccines are usually contraindicated in immunocompromised patients; however, there are exceptions. MMR is recommended and varicella should be considered for adults with CD4+ T-lymphocyte counts of greater than or equal to 200cell/ μ L. Immunosuppressed patients should not receive LAIV. For details, consult current ACIP recommendations.^{1,6,7,8}

7. In the past 3 months, have you taken medications that weaken your immune system, such as prednisone or other steroids; anticancer drugs; biologic drugs for autoimmune diseases such as rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? [Adenovirus, Cholera, MMR, SPV, Ty21a, VAR, YF-Vax, ZVL]

Live virus vaccines should be postponed until after chemotherapy or long-term, high-dose steroid therapy has ended. For details and length of time to postpone, consult the current ACIP statement.¹ Some immune mediator and immune modulator drugs (especially the antitumor necrosis factor agents adalimumab, infliximab, and etanercept) may be immunosuppressive. The use of live vaccines should be avoided in persons taking these drugs.¹ Specific vaccination schedules for stem cell transplant (bone marrow transplant) patients can be found on the NIH website.⁸ LAIV, when recommended, can be given only to healthy, non-pregnant people ages 2 through 49 years.

8. In the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?

[MMR, VAR]

Certain live virus vaccines may need to be deferred, depending on several variables. Consult the most current ACIP recommendations for information on intervals between receipt of antiviral drugs, immune globulin or blood products, and live virus vaccines.^{1,7}

9. Have you had (or are you a candidate for) your spleen removed, or do you have sickle cell anemia? [Hib, LAIV, PCV13, PPSV23, MCV4, MenB]

Patients with anatomic or functional asplenia (i.e. sickle-cell disease) are at an increased risk of certain vaccine preventable diseases to include Haemophilus influenzae type b, meningococcal, and pneumococcal disease. LAIV is not recommended for people with anatomic or functional asplenia. Hib, PCV13, MCV4, and MenB vaccine should be given 14 days before splenectomy, if possible. Doses given during the 14 days prior to surgery can be counted as valid. Doses that cannot be given prior to surgery should be given as soon as the patient's condition has stabilized after surgery. For patients 2 years of age and up: the first dose of PPSV23 should be administered 8 weeks after the last dose of PCV13. A second dose of PPSV23 should be administered 5 years after the first dose. A third, final dose of PPSV23 should be administered after age 65 years, if both previous doses were before the age of 65.

10. Have you ever passed out (had vasovagal syncope) during or after a previous immunization or blood draw? [all vaccines]

Providers should be aware of the potential for syncope (fainting) associated with vaccination, particularly among adolescents. Appropriate measures should be taken to prevent syncope, and to readily respond to the patient who feels faint. Observe all patients for 15 minutes after vaccination for signs and symptoms that precede syncope, such as weakness, dizziness, sweatiness, and pallor. For patients prone to syncope, make sure they are either seated or lying down at the time of vaccination. (If the patient is seated during vaccination, the immunizer should be seated as well, to minimize the risk of SIRVA). If a patient becomes pre-syncope, have them lie flat or sit with head between knees for several minutes; loosen any tight clothing and maintain an open airway; apply cool, damp cloths to the patient's face and neck. Observe the patient until symptoms completely resolve.

11. Have you received any vaccinations in the past 4 weeks? [LAIV, MMR, SPV, VAR, YF-Vax, ZVL]

Patients who were given either LAIV, SPV, or an injectable live virus vaccine should wait 28 days before receiving another live vaccine. Inactivated vaccines may be given at the same time or at any spacing interval.

12. Are you pregnant, or is there a chance you could become pregnant during the next month? [Adenovirus, HPV, IPV, MMR, LAIV, VAR, SPV, Ty21a, possibly YF-Vax, ZVL]

Live virus vaccines are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active women who receive a live virus vaccine should be instructed to practice careful contraception for one month following receipt.^{6,9} On theoretical grounds, HPV and IPV should not be given during pregnancy; however, IPV may be given if risk of exposure is imminent (e.g., travel to endemic areas). Inactivated influenza vaccine and Tdap are both recommended during pregnancy. Both vaccines may be given at any time during pregnancy, but the preferred time for Tdap administration is at 27-36 weeks gestation.¹⁰

1. ACIP General Best Practice Guidelines for Immunization: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/downloads/general-recs.pdf.
2. Latex in Vaccine Packaging: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latexable.pdf.
3. Table of Vaccine Components: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/exipient-table-2.pdf.
4. Prevention and control of seasonal influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices. www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html.
5. Measles, mumps, and rubella-vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. MMWR 1998, 47(RR-8).
6. Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices. MMWR 2007, 56(RR-4).

7. Rubin L.G., Levin M.J., Ljungman P. (2014) IDSA Clinical practice guideline for vaccination of the immunocompromised host. *Clinical Infectious Diseases*, 58(3), 309–318
8. Tomblyn M, Einsele H, et al. 2009. Guidelines for preventing infectious complications among hematopoietic stem cell transplant recipients: a global perspective. *Biology of Blood and Marrow Transplant* 15:1143-1238.
9. Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. MMWR 2001; 50(49).
10. Updated recommendations for use of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap) in pregnant women: ACIP. MMWR 2012 62(07):131-135.

Vaccine Abbreviations:

- Hib: *Haemophilus influenza* type b
- HPV: human papillomavirus
- IIV: inactivated influenza
- IPV: inactivated poliovirus
- LAIV: live attenuated influenza
- MCV4: meningococcal conjugate, quadrivalent, serogroups A, C, W, Y
- MenB: meningococcal serogroup B
- MMR: measles, mumps, rubella
- PPSV23: pneumococcal polysaccharide (23-valent)
- RIV: recombinant influenza
- SIRVA: shoulder injury related to vaccine administration
- SPV: vaccinia (smallpox)
- Td: tetanus/diphtheria toxoids
- Tdap: tetanus toxoid, reduced diphtheria toxoid, acellular pertussis
- Ty21a: oral typhoid
- VAR: varicella
- YF-Vax: yellow fever
- ZVL: zoster vaccine live

INITIAL ENTRY TUBERCULOSIS (TB) RISK ASSESSMENT TOOL

For use of this form see, MEDCOM Reg 40-64, the proponent agency is MCPO-SA

INITIAL ENTRY Tuberculosis (TB) Risk Assessment Tool		REVIEWER INSTRUCTION
1. Have you ever had face-to-face contact with someone who was sick with tuberculosis (TB)?	☐ Yes ☐ No	
2. Were you born outside the United States? If yes, list country: _____	☐ Yes ☐ No	
3. Did you ever live with a family member that was born outside the United States? If yes, list country: _____	☐ Yes ☐ No	
4. Have you ever had a positive TB test, prior diagnosis of TB, or prior treatment for TB?	☐ Yes ☐ No	
If "NO" answers = low risk → STOP. Any "YES" answers = increase risk → Go to question #5		If all "NO" responses, Then do not test
5. Do you have any of the following symptoms of tuberculosis? Cough > 2 weeks, fever > 2 weeks, drenching night sweats, or unplanned weight loss?	☐ Yes ☐ No	
If "YES" → STOP. Any "NO" → Go to question #6		If "YES" then refer immediately to provider for evaluation of TB disease.
6. Do you have documentation of previous TB treatment with you today?	☐ Yes ☐ No STOP.	
Reviewer comments		If "YES" → Do NOT test. Document exemption in MEDPROS If "NO" → Test for TB. Note: If "Yes" response only to Question 2 or 3 above, testing is only required if the country is Listed on the reverse side.
PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last-first-middle; DOB; SSN; date; hospital or medical facility) NAME: DOB: DoD ID #: DATE:	REVIEWER NAME	REVIEWER SIGNATURE

The following countries, if documented on the TB Risk Assessment Tool, indicate need for patient to be tested:

Afghanistan	Egypt	Malaysia	Senegal
Algeria	El Salvador	Maldives	Serbia
Angola	Equatorial Guinea	Mali	Serbia & Montenegro
Anguilla	Eritrea	Marshall Islands	Seychelles
Argentina	Estonia	Mauritania	Sierra Leone
Armenia	Ethiopia	Mauritius	Singapore
Azerbaijan	Fiji	Micronesia – Fed States	Solomon Islands
Bahrain	French Polynesia	Moldova	Somalia
Bangladesh	Gabon	Mongolia	South Africa
Belarus	Gambia	Montenegro	Sri Lanka
Belize	Georgia	Montserrat	Sudan
Benin	Ghana	Morocco	Suriname
Bhutan	Guam	Mozambique	Swaziland
Bolivia	Guatemala	Myanmar	Syrian Arab Republic
Bosnia & Herzegovina	Guinea	N. Mariana Islands	Tajikistan
Botswana	Guinea – Bissau	Namibia	Tanzania-UR
Brazil	Guyana	Nauru	Thailand
British Virgin Islands	Haiti	Nepal	Timor-Leste
Brunei Darussalam	Honduras	New Caledonia	Togo
Bulgaria	India	Nicaragua	Tonga
Burkina Faso	Indonesia	Niger	Trinidad & Tobago
Burundi	Iran	Nigeria	Tunisia
Cambodia	Iraq	Pakistan	Turkey
Cameroon	Japan	Palau	Turkmenistan
Cape Verde	Kazakhstan	Panama	Turks & Caicos Islands
Central African Republic	Kenya	Papua New Guinea	Tuvalu
Chad	Kiribati	Paraguay	Uganda
China	Korea – DR	Peru	Ukraine
China, Hong Kong SAR	Korea – Rep of	Philippines	Uruguay
China, Macao SAR	Kuwait	Poland	Uzbekistan
Colombia	Kyrgyzstan	Portugal	Vanuatu
Comoros	Lao PDR	Qatar	Venezuela
Congo	Latvia	Romania	Viet Nam
Congo – DR	Lesotho	Russian Federation	Wallis & Futuna Islands
Cook Islands	Liberia	Rwanda	West Bank & Gaza Strip
Cote d'Ivoire	Libya	St. Vincent & Grenadines	Yemen
Croatia	Lithuania	Samoa	Zambia
Djibouti	Macedonia	Sao Tome & Principe	Zimbabwe
Dominican Republic	Madagascar	Saudi Arabia	
Ecuador	Malawi		

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://dpclid.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		15c. PURPOSE OF EXAMINATION ☐ 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)		
MEDICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.)						43. DENTAL DEFECTS AND DISEASE Acceptable ☐ (Please explain. Use dental form if completed by dentist. If abnormality noted, explain in item 44.) Not Acceptable ☐ Class _____		
17. Head, face, neck and scalp				Normal	Abnormal	NE	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.)	
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								

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	72c. OTHER TESTING																	
Left							Left																								
Right							Right																								
73. NOTES AND/OR INTERVAL HISTORY																															

89. ADDITIONAL REMARKS

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 Oct 31, 2017	
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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Directives Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (0704-0413). 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, DoD Instruction 6130.03, and E.O. 9397, as amended (SSN). 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. Completed forms are covered by recruiting, medical evaluation board, and official military personnel file SORNs maintained by each of the Services. ROUTINE USE(S): The Blanket Routine Uses found at http://dpcl.dod.mil/Privacy/SORNsIndex/BlanketRoutineUses.aspx apply to this collection. 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. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.					
1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)		2. SOCIAL SECURITY NUMBER		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)		Fox Army Health Center 4100 Goss Road Redstone Arsenal, AL 35809-7000			
X ALL APPLICABLE BOXES:					7.a. POSITION (Title, Grade, Component)
6.a. SERVICE ☐ Army ☐ Coast Guard ☐ Navy ☐ Marine Corps ☐ Air Force		6.b. COMPONENT ☐ Regular ☐ Reserve ☐ National Guard		6.c. PURPOSE OF EXAMINATION ☐ Enlistment ☐ Medical Board ☐ Other (Specify) ☐ Commission ☐ Retirement ☐ Retention ☐ U.S. Service Academy ☐ Separation ☐ ROTC Scholarship Program	
8. CURRENT MEDICATIONS (Prescription and Over-the-counter)					b. USUAL OCCUPATION
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:				12. (Continued)	
10.a. Tuberculosis				f. Foot trouble (e.g., pain, corns, bunions, etc.)	
b. Lived with someone who had tuberculosis				g. Impaired use of arms, legs, hands, or feet	
c. Coughed up blood				h. Swollen or painful joint(s)	
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.				i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	
e. Shortness of breath				j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	
f. Bronchitis				k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	
g. Wheezing or problems with wheezing				l. Bone, joint, or other deformity	
h. Been prescribed or used an inhaler				m. Plate(s), screw(s), rod(s) or pin(s) in any bone	
i. A chronic cough or cough at night				n. Broken bone(s) (cracked or fractured)	
j. Sinusitis				13.a. Frequent indigestion or heartburn	
k. Hay fever				b. Stomach, liver, intestinal trouble, or ulcer	
l. Chronic or frequent colds				c. Gall bladder trouble or gallstones	
11.a. Severe tooth or gum trouble				d. Jaundice or hepatitis (liver disease)	
b. Thyroid trouble or goiter				e. Rupture/hernia	
c. Eye disorder or trouble				f. Rectal disease, hemorrhoids or blood from the rectum	
d. Ear, nose, or throat trouble				g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	
e. Loss of vision in either eye				h. Frequent or painful urination	
f. Worn contact lenses or glasses				i. High or low blood sugar	
g. A hearing loss or wear a hearing aid				j. Kidney stone or blood in urine	
h. Surgery to correct vision (RK, PRK, LASIK, etc.)				k. Sugar or protein in urine	
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)				l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	
b. Arthritis, rheumatism, or bursitis				14.a. Adverse reaction to serum, food, insect stings or medicine	
c. Recurrent back pain or any back problem				b. Recent unexplained gain or loss of weight	
d. Numbness or tingling				c. Currently in good health (If no, explain in Item 29 on Page 2.)	
e. Loss of finger or toe				d. Tumor, growth, cyst, or cancer	

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
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	☐ YES ☐ NO
b. Frequent or severe headache	☐ YES ☐ NO
c. A head injury, memory loss or amnesia	☐ YES ☐ NO
d. Paralysis	☐ YES ☐ NO
e. Seizures, convulsions, epilepsy or fits	☐ YES ☐ NO
f. Car, train, sea, or air sickness	☐ YES ☐ NO
g. A period of unconsciousness or concussion	☐ YES ☐ NO
h. Meningitis, encephalitis, or other neurological problems	☐ YES ☐ NO
16.a. Rheumatic fever	☐ YES ☐ NO
b. Prolonged bleeding (<i>as after an injury or tooth extraction, etc.</i>)	☐ YES ☐ NO
c. Pain or pressure in the chest	☐ YES ☐ NO
d. Palpitation, pounding heart or abnormal heartbeat	☐ YES ☐ NO
e. Heart trouble or murmur	☐ YES ☐ NO
f. High or low blood pressure	☐ YES ☐ NO
17.a. Nervous trouble of any sort (<i>anxiety or panic attacks</i>)	☐ YES ☐ NO
b. Habitual stammering or stuttering	☐ YES ☐ NO
c. Loss of memory or amnesia, or neurological symptoms	☐ YES ☐ NO
d. Frequent trouble sleeping	☐ YES ☐ NO
e. Received counseling of any type	☐ YES ☐ NO
f. Depression or excessive worry	☐ YES ☐ NO
g. Been evaluated or treated for a mental condition	☐ YES ☐ NO
h. Attempted suicide	☐ YES ☐ NO
i. Used illegal drugs or abused prescription drugs	☐ YES ☐ NO
18. FEMALES ONLY. Have you ever had or do you now have:	
a. Treatment for a gynecological (female) disorder	☐ YES ☐ NO
b. A change of menstrual pattern	☐ YES ☐ NO
c. Any abnormal PAP smears	☐ YES ☐ NO
d. First day of last menstrual period (YYYYMMDD)	☐ YES ☐ NO
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.	☐ YES ☐ NO
b. Inability to perform certain motions	☐ YES ☐ NO
c. Inability to stand, sit, kneel, lie down, etc.	☐ YES ☐ NO
d. Other medical reasons (<i>If yes, give reasons.</i>)	☐ YES ☐ NO
20. Have you ever been treated in an Emergency Room? (<i>If yes, for what?</i>)	☐ YES ☐ NO
21. Have you ever been a patient in any type of hospital? (<i>If yes, specify when, where, why, and name of doctor and complete address of hospital.</i>)	☐ YES ☐ NO
22. Have you ever had, or have you been advised to have any operations or surgery? (<i>If yes, describe and give age at which occurred.</i>)	☐ YES ☐ NO
23. Have you ever had any illness or injury other than those already noted? (<i>If yes, specify when, where, and give details.</i>)	☐ YES ☐ NO
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (<i>If yes, give complete address of doctor, hospital, clinic, and details.</i>)	☐ YES ☐ NO
25. Have you ever been rejected for military service for any reason? (<i>If yes, give date and reason for rejection.</i>)	☐ YES ☐ NO
26. Have you ever been discharged from military service for any reason? (<i>If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.</i>)	☐ YES ☐ NO
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (<i>If yes, specify what kind, granted by whom, and what amount, when, why.</i>)	☐ YES ☐ NO
28. Have you ever been denied life insurance?	☐ YES ☐ NO
29. EXPLANATION OF "YES" ANSWER(S) (<i>Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.</i>)	

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

