

## REPORT OF MEDICAL EXAMINATION

|   |         |                                   |                                    |  |                        |                 |
|---|---------|-----------------------------------|------------------------------------|--|------------------------|-----------------|
| 1. LAST NAME - FIRST NAME - MIDDLE NAME                                   |         |                                   | 2. GRADE AND COMPONENT OR POSITION |  | 3. IDENTIFICATION NO.  |                 |
| 4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code) |         |                                   | 5. PURPOSE OF EXAMINATION          |  | 6. DATE OF EXAMINATION |                 |
| 7. SEX  | 8. RACE | 9. TOTAL YEARS GOVERNMENT SERVICE |                                    | 10. AGENCY   | 11. ORGANIZATION UNIT  |                 |
|   |         | MILITARY                          | CIVILIAN                           |  |                        |                 |
| 12. DATE OF BIRTH   |         | 13. PLACE OF BIRTH                |                                    | 14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN |                        |                 |
| 15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS                           |         |                                   |                                    | 16. OTHER INFORMATION                              |                        |                 |
| 17. RATING OR SPECIALTY   |         |                                   |                                    | TIME IN THIS CAPACITY (Total)                      |                        | LAST SIX MONTHS |

| NOR-MAL | (Check each item in appropriate column, enter "NE" if not evaluated.)      | ABNOR-MAL |
|---------|--|-----------|
|         | 18. HEAD, FACE, NECK AND SCALP   |           |
|         | 19. NOSE   |           |
|         | 20. SINUSES  |           |
|         | 21. MOUTH AND THROAT   |           |
|         | 22. EARS-GENERAL (INTERNAL CANALS) (Auditory acuity under items 70 and 71) |           |
|         | 23. DRUMS (Perforation)  |           |
|         | 24. EYES-GENERAL (Visual acuity and refraction under items 59, 60 and 67)  |           |
|         | 25. OPHTHALMOSCOPIC-   |           |
|         | 26. PUPILS (Equality and reaction)   |           |
|         | 27. OCULAR MOTILITY (Associated parallel movements nystagmus)              |           |
|         | 28. LUNGS AND CHEST (Include breasts)                                      |           |
|         | 29. HEART (Thrust, size, rhythm, sounds)                                   |           |
|         | 30. VASCULAR SYSTEM (Varicosities, etc.)                                   |           |
|         | 31. ABDOMEN AND VISCERA (Include hernia)                                   |           |
|         | 32. ANUS AND RECTUM (Hemorrhoids, Fistular Prostate, if indicated)         |           |
|         | 33. ENDOCRINE SYSTEM   |           |
|         | 34. G-U SYSTEM   |           |
|         | 35. UPPER EXTREMITIES (Strength, range of motion)                          |           |
|         | 36. FEET   |           |
|         | 37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)            |           |
|         | 38. SPINE, OTHER MUSCULOSKELETAL   |           |
|         | 39. IDENTIFYING BODY MARKS, SCARS, TATTOOS                                 |           |
|         | 40. SKIN, LYMPHATICS   |           |
|         | 41. NEUROLOGIC (Equilibrium tests under item 72)                           |           |
|         | 42. PSYCHIATRIC (Specify any personality deviation)                        |           |
|         | 43. PELVIC (Females only) (Check how done)                                 |           |
|         | <input type="checkbox"/> VAGINAL <input type="checkbox"/> RECTAL           |           |

**NOTES:** (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)

(Continue in item 73)

|   |            |          |                |          |         |          |                      |            |          |                        |       |         |       |                      |       |  |                  |       |                        |          |       |          |       |          |       |          |       |       |          |       |   |  |   |  |   |  |   |   |   |       |  |  |  |  |  |  |  |  |  |
|---|------------|----------|----------------|----------|---------|----------|----------------------|------------|----------|------------------------|-------|---------|-------|----------------------|-------|--|------------------|-------|------------------------|----------|-------|----------|-------|----------|-------|----------|-------|-------|----------|-------|---|--|---|--|---|--|---|---|---|-------|--|--|--|--|--|--|--|--|--|
| 44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)  |            |          |                |          |         |          |                      |            |          |                        |       |         |       |                      |       | REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES |                  |       |                        |          |       |          |       |          |       |          |       |       |          |       |   |  |   |  |   |  |   |   |   |       |  |  |  |  |  |  |  |  |  |
| <table style="margin: auto;"> <tr><td>0</td><td>/</td><td>x</td><td>x</td><td>x</td></tr> <tr><td>1 2 3</td><td>Restorable</td><td>1 2 3</td><td>Non-Restorable</td><td>1 2 3</td><td>Missing</td><td>1 2 3</td><td>Replaced by Dentures</td><td>( x )</td><td>1 2 3</td><td>Fixed Partial dentures</td></tr> <tr><td>32 31 30</td><td>Teeth</td><td>32 31 30</td><td>Teeth</td><td>32 31 30</td><td>Teeth</td><td>32 31 30</td><td>Teeth</td><td>( x )</td><td>32 31 30</td><td>Teeth</td></tr> <tr><td>0</td><td></td><td>/</td><td></td><td>x</td><td></td><td>x</td><td>x</td><td>x</td><td>( x )</td><td></td></tr> </table> |            | 0        | /              | x        | x       | x        | 1 2 3                | Restorable | 1 2 3    | Non-Restorable         | 1 2 3 | Missing | 1 2 3 | Replaced by Dentures | ( x ) |  |                  | 1 2 3 | Fixed Partial dentures | 32 31 30 | Teeth | ( x ) | 32 31 30 | Teeth | 0 |  | / |  | x |  | x | x | x | ( x ) |  |  |  |  |  |  |  |  |  |
| 0   | /          | x        | x              | x        |         |          |                      |            |          |                        |       |         |       |                      |       |  |                  |       |                        |          |       |          |       |          |       |          |       |       |          |       |   |  |   |  |   |  |   |   |   |       |  |  |  |  |  |  |  |  |  |
| 1 2 3   | Restorable | 1 2 3    | Non-Restorable | 1 2 3    | Missing | 1 2 3    | Replaced by Dentures | ( x )      | 1 2 3    | Fixed Partial dentures |       |         |       |                      |       |  |                  |       |                        |          |       |          |       |          |       |          |       |       |          |       |   |  |   |  |   |  |   |   |   |       |  |  |  |  |  |  |  |  |  |
| 32 31 30  | Teeth      | 32 31 30 | Teeth          | 32 31 30 | Teeth   | 32 31 30 | Teeth                | ( x )      | 32 31 30 | Teeth                  |       |         |       |                      |       |  |                  |       |                        |          |       |          |       |          |       |          |       |       |          |       |   |  |   |  |   |  |   |   |   |       |  |  |  |  |  |  |  |  |  |
| 0   |            | /        |                | x        |         | x        | x                    | x          | ( x )    |                        |       |         |       |                      |       |  |                  |       |                        |          |       |          |       |          |       |          |       |       |          |       |   |  |   |  |   |  |   |   |   |       |  |  |  |  |  |  |  |  |  |
| R<br>I<br>G<br>H<br>T   | 1          | 2        | 3              | 4        | 5       | 6        | 7                    | 8          | 9        | 10                     | 11    | 12      | 13    | 14                   | 15    | 16   | L<br>E<br>F<br>T |       |                        |          |       |          |       |          |       |          |       |       |          |       |   |  |   |  |   |  |   |   |   |       |  |  |  |  |  |  |  |  |  |
|   | 32         | 31       | 30             | 29       | 28      | 27       | 26                   | 25         | 24       | 23                     | 22    | 21      | 20    | 19                   | 18    | 17   |                  |       |                        |          |       |          |       |          |       |          |       |       |          |       |   |  |   |  |   |  |   |   |   |       |  |  |  |  |  |  |  |  |  |

### LABORATORY FINDINGS

|   |  |                |  |   |                              |  |                 |
|---|--|----------------|--|---|------------------------------|--|-----------------|
| 45. URINALYSIS: A. SPECIFIC GRAVITY         |  |                |  | 46. CHEST X-RAY (Place, date, film number and result) |                              |  |                 |
| B. ALBUMIN                                  |  | D. MICROSCOPIC |  |   |                              |  |                 |
| C. SUGAR                                    |  |                |  |   |                              |  |                 |
| 47. SEROLOGY (Specify test used and result) |  |                |  | 48. EKG   | 49. BLOOD TYPE AND RH FACTOR |  | 50. OTHER TESTS |

**MEASUREMENTS AND OTHER FINDINGS**

|  |  |                 |  |  |  |   |            |  |              |                   |              |   |  |                             |  |              |              |              |
|--|--|-----------------|--|--|--|---|------------|--|--------------|-------------------|--------------|---|--|-----------------------------|--|--------------|--------------|--------------|
| 51. HEIGHT   |  | 52. WEIGHT      |  | 53. COLOR HAIR                                   |  | 54. COLOR EYES                          |            | 55. BUILD:<br><input type="checkbox"/> SLENDER <input type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESE |              |                   |              | 56. TEMPERATURE   |  |                             |  |              |              |              |
| 57. BLOOD PRESSURE ( <i>Arm at heart level</i> )                   |  |                 |  |  |  | 58. PULSE ( <i>Arm at heart level</i> ) |            |  |              |                   |              |   |  |                             |  |              |              |              |
| A. SITTING   |  | B. RECUMBENT    |  | C. STANDING<br>(5 min.)                          |  | A. SITTING                              |            | B. AFTER EXERCISE  |              | C. 2 MIN. AFTER   |              | D. RECUMBENT  |  | E. AFTER STANDING<br>3 MIN. |  |              |              |              |
| SYS.   |  | SYS.            |  | SYS.   |  | A. SITTING                              |            | B. AFTER EXERCISE  |              | C. 2 MIN. AFTER   |              | D. RECUMBENT  |  | E. AFTER STANDING<br>3 MIN. |  |              |              |              |
| DIAS.  |  | DIAS.           |  | DIAS.  |  | A. SITTING                              |            | B. AFTER EXERCISE  |              | C. 2 MIN. AFTER   |              | D. RECUMBENT  |  | E. AFTER STANDING<br>3 MIN. |  |              |              |              |
| 59. DISTANT VISION   |  |                 |  | 60. REFRACTION                                   |  |   |            | 61. NEAR VISION  |              |                   |              |   |  |                             |  |              |              |              |
| RIGHT 20/  |  | CORR. TO 20/    |  | BY   |  | S.                                      |            | CX   |              | CORR. TO          |              | BY  |  |                             |  |              |              |              |
| LEFT 20/   |  | CORR. TO 20/    |  | BY   |  | S.                                      |            | CX   |              | CORR. TO          |              | BY  |  |                             |  |              |              |              |
| 62. HETEROPHORIA ( <i>Specify distance</i> )                       |  |                 |  |  |  |   |            |  |              |                   |              |   |  |                             |  |              |              |              |
| ES <sup>o</sup>  |  | EX <sup>o</sup> |  | R.H.   |  | L.H.                                    |            | PRISM DIV.   |              | PRISM CONV.<br>CT |              | PC  |  | PD                          |  |              |              |              |
| 63. ACCOMMODATION  |  |                 |  | 64. COLOR VISION ( <i>Test used and result</i> ) |  |   |            | 65. DEPTH PERCEPTION<br>( <i>Test used and score</i> )   |              |                   |              | UNCORRECTED   |  |                             |  |              |              |              |
| RIGHT  |  |                 |  | 64. COLOR VISION ( <i>Test used and result</i> ) |  |   |            | 65. DEPTH PERCEPTION<br>( <i>Test used and score</i> )   |              |                   |              | CORRECTED   |  |                             |  |              |              |              |
| LEFT   |  |                 |  | 64. COLOR VISION ( <i>Test used and result</i> ) |  |   |            | 65. DEPTH PERCEPTION<br>( <i>Test used and score</i> )   |              |                   |              | CORRECTED   |  |                             |  |              |              |              |
| 66. FIELD OF VISION  |  |                 |  | 65. NIGHT VISION ( <i>Test used and score</i> )  |  |   |            | 66. RED LENS TEST  |              |                   |              | 69. INTRAOCULAR TENSION   |  |                             |  |              |              |              |
| 66. FIELD OF VISION  |  |                 |  | 65. NIGHT VISION ( <i>Test used and score</i> )  |  |   |            | 66. RED LENS TEST  |              |                   |              | 69. INTRAOCULAR TENSION   |  |                             |  |              |              |              |
| 66. FIELD OF VISION  |  |                 |  | 65. NIGHT VISION ( <i>Test used and score</i> )  |  |   |            | 66. RED LENS TEST  |              |                   |              | 69. INTRAOCULAR TENSION   |  |                             |  |              |              |              |
| 70. HEARING  |  |                 |  | 71. AUDIOMETER                                   |  |   |            |  |              |                   |              | 72. PSYCHOLOGICAL AND PSYCHOMOTOR<br>( <i>Test used and score</i> ) |  |                             |  |              |              |              |
| RIGHT WV   |  | /15 SV          |  | /15  |  |   | 250<br>256 | 500<br>512   | 1000<br>1024 | 2000<br>2048      | 3000<br>2896 |   |  |                             |  | 4000<br>4096 | 6000<br>6144 | 8000<br>8192 |
| LEFT WV  |  | /15 SV          |  | /15  |  |   |            |  |              |                   |              |   |  |                             |  |              |              |              |
|  |  |                 |  |  |  |   |            |  |              |                   |              |   |  |                             |  |              |              |              |
| 73. NOTES ( <i>Continued</i> ) AND SIGNIFICANT OR INTERVAL HISTORY |  |                 |  |  |  |   |            |  |              |                   |              |   |  |                             |  |              |              |              |

*(Use additional sheets if necessary)*

|  |  |  |  |  |  |  |  |  |  |  |  |                          |   |   |   |   |   |
|--|--|--|--|--|--|--|--|--|--|--|--|--------------------------|---|---|---|---|---|
| 74. SUMMARY OF DEFECTS AND DIAGNOSES ( <i>List diagnosis with item numbers</i> ) |  |  |  |  |  |  |  |  |  |  |  |                          |   |   |   |   |   |
| 75. RECOMMENDATIONS-FURTHER SPECIALIST EXAMINATIONS INDICATED ( <i>Specify</i> ) |  |  |  |  |  |  |  |  |  |  |  | 76. A. PHYSICAL PROFILE  |   |   |   |   |   |
|  |  |  |  |  |  |  |  |  |  |  |  | P                        | U | L | H | E | S |
| 77. EXAMINEE ( <i>Check</i> )  |  |  |  |  |  |  |  |  |  |  |  | 76. B. PHYSICAL CATEGORY |   |   |   |   |   |
| A. <input type="checkbox"/> IS QUALIFIED FOR                                     |  |  |  |  |  |  |  |  |  |  |  |                          |   |   |   |   |   |
| B. <input type="checkbox"/> IS NOT QUALIFIED FOR                                 |  |  |  |  |  |  |  |  |  |  |  | 76. B. PHYSICAL CATEGORY |   |   |   |   |   |
| 78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER                  |  |  |  |  |  |  |  |  |  |  |  | A                        | B | C | E |   |   |

|   |  |  |  |  |  |  |  |           |  |  |  |                           |  |
|---|--|--|--|--|--|--|--|-----------|--|--|--|---------------------------|--|
| 79. TYPED OR PRINTED NAME OF PHYSICIAN                                      |  |  |  |  |  |  |  | SIGNATURE |  |  |  |                           |  |
| 80. TYPED OR PRINTED NAME OF PHYSICIAN                                      |  |  |  |  |  |  |  | SIGNATURE |  |  |  |                           |  |
| 81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN ( <i>Indicate which</i> ) |  |  |  |  |  |  |  | SIGNATURE |  |  |  |                           |  |
| 82. TYPED OR PRINTED NAME OR REVIEWING OFFICER OR APPROVING AUTHORITY       |  |  |  |  |  |  |  | SIGNATURE |  |  |  | NUMBER OF ATTACHED SHEETS |  |