

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

CLINICAL EVALUATION		
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. OPHTHALMOSCOPIE-	
	26. PUPILS (Equality and reaction)	
	27. OCULAR MOTILITY (Associated parallel movements nysingmus)	
	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.)																																																																																																															
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REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

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: <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	SYS.	B. RECUMBENT	SYS.	C. STANDING (5 min.)	SYS.	A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.		
	DIAS.		DIAS.		DIAS.							
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°	EX°	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD					
63. ACCOMMODATION			64. COLOR VISION (<i>Test used and result</i>)				65. DEPTH PERCEPTION (<i>Test used and score</i>)		UNCORRECTED			
RIGHT	LEFT								CORRECTED			
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 (<i>Test used and score</i>)			
RIGHT WV	/15 SV	/15	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096			6000 6144	8000 8192
			RIGHT									
LEFT WV	/15 SV	/15	LEFT									

(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>)					B. PHYSICAL CATEGORY						
A. <input type="checkbox"/> IS QUALIFIED FOR											
B. <input type="checkbox"/> IS NOT QUALIFIED FOR					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		