

MEDICAL RECORD		REPORT OF MEDICAL EXAMINATION			DATE OF EXAM
1. LAST NAME - FIRST NAME - MIDDLE NAME		2. IDENTIFICATION NO.		3. GRADE AND COMPONENT OR POSITION	
4. HOME ADDRESS <i>(Number, street or RFD, city or town, state and ZIP Code)</i>		5. EMERGENCY CONTACT <i>(Name and address of contact)</i>			
6. DATE OF BIRTH	7. AGE	8. SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE		9. RELATIONSHIP OF CONTACT	
10. PLACE OF BIRTH		11. RACE <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> AMERICAN INDIAN/ ALASKA NATIVE <input type="checkbox"/> HISPANIC WHITE <input type="checkbox"/> HISPANIC BLACK <input type="checkbox"/> ASIAN/PACIFIC ISLANDER			
12a. AGENCY		12b. ORGANIZATION UNIT		13. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY b. CIVILIAN	
14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS		15. RATING OR SPECIALTY OF EXAMINER			
		16. PURPOSE OF EXAMINATION			

17. CLINICAL EVALUATION

NOR-MAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNOR-MAL	NOR-MAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNOR-MAL
	A. HEAD, FACE, NECK AND SCALP			O. PROSTATE <i>(Over 40 or clinically indicated)</i>	
	B. EARS - GENERAL <i>(INTERNAL CANALS)</i> <i>(Auditory acuity under items 39 and 40)</i>			P. TESTICULAR	
	C. DRUMS <i>(Perforation)</i>			Q. ANUS AND RECTUM <i>(Hemorrhoids, Fistulae)</i> <i>(Hemocult Results)</i>	
	D. NOSE			R. ENDOCRINE SYSTEM	
	E. SINUSES			S. G-U SYSTEM	
	F. MOUTH AND THROAT			T. UPPER EXTREMITIES <i>(Strength, range of motion)</i>	
	G. EYES GENERAL <i>(Visual acuity and refraction under items 28, 29, and 30)</i>			U. FEET	
	H. OPHTHALMOSCOPIC			V. LOWER EXTREMITIES <i>(Except feet)</i> <i>(Strength, range of motion)</i>	
	I. PUPILS <i>(Equality and reaction)</i>			W. SPINE, OTHER MUSCULOSKELETAL	
	J. OCULAR MOTILITY <i>(Associated parallel movements nystagmus)</i>			X. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	K. LUNGS AND CHEST			Y. SKIN, LYMPHATICS	
	L. HEART <i>(Thrust, size, rhythm, sounds)</i>			Z. NEUROLOGIC <i>(Equilibrium tests under item 42)</i>	
	M. VASCULAR SYSTEM <i>(Varicosities, etc.)</i>			AA. PSYCHIATRIC <i>(Specify any personality deviation)</i>	
	N. ABDOMEN AND VISCERA <i>(Include hernia)</i>			BB. BREASTS	
				CC. PELVIC <i>(Females only)</i>	

NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary)*

<p>18. DENTAL <i>(Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)</i></p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"> $\begin{array}{ccccccc} & & 0 & & / & & x \\ & & \underline{1} & \underline{2} & \underline{3} & & \underline{x} & \underline{x} & \underline{x} \\ & & 32 & 31 & 30 & & 32 & 31 & 30 \end{array}$ </td> <td style="text-align: center;">Restorable Teeth</td> <td style="text-align: center;"> $\begin{array}{ccccccc} & & 1 & \underline{2} & \underline{3} & & x \\ & & \underline{32} & \underline{31} & \underline{30} & & \underline{32} & \underline{31} & \underline{30} \end{array}$ </td> <td style="text-align: center;">Non- restorable Teeth</td> <td style="text-align: center;"> $\begin{array}{ccccccc} & & x & & & & x \\ & & \underline{1} & \underline{2} & \underline{3} & & \underline{x} & \underline{x} & \underline{x} \\ & & 32 & 31 & 30 & & 32 & 31 & 30 \end{array}$ </td> <td style="text-align: center;">Missing Teeth</td> <td style="text-align: center;"> $\begin{array}{ccccccc} & & x & x & x & & \\ & & \underline{1} & \underline{2} & \underline{3} & & \\ & & 32 & 31 & 30 & & \end{array}$ </td> <td style="text-align: center;">Replaced by Dentures</td> <td style="text-align: center;"> $\begin{array}{ccccccc} & & (& x &) & & \\ & & \underline{1} & \underline{2} & \underline{3} & & \\ & & 32 & 31 & 30 & & \end{array}$ </td> <td style="text-align: center;">Fixed Partial Dentures</td> </tr> </table>	$\begin{array}{ccccccc} & & 0 & & / & & x \\ & & \underline{1} & \underline{2} & \underline{3} & & \underline{x} & \underline{x} & \underline{x} \\ & & 32 & 31 & 30 & & 32 & 31 & 30 \end{array}$	Restorable Teeth	$\begin{array}{ccccccc} & & 1 & \underline{2} & \underline{3} & & x \\ & & \underline{32} & \underline{31} & \underline{30} & & \underline{32} & \underline{31} & \underline{30} \end{array}$	Non- restorable Teeth	$\begin{array}{ccccccc} & & x & & & & x \\ & & \underline{1} & \underline{2} & \underline{3} & & \underline{x} & \underline{x} & \underline{x} \\ & & 32 & 31 & 30 & & 32 & 31 & 30 \end{array}$	Missing Teeth	$\begin{array}{ccccccc} & & x & x & x & & \\ & & \underline{1} & \underline{2} & \underline{3} & & \\ & & 32 & 31 & 30 & & \end{array}$	Replaced by Dentures	$\begin{array}{ccccccc} & & (& x &) & & \\ & & \underline{1} & \underline{2} & \underline{3} & & \\ & & 32 & 31 & 30 & & \end{array}$	Fixed Partial Dentures	<p>REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES</p>
$\begin{array}{ccccccc} & & 0 & & / & & x \\ & & \underline{1} & \underline{2} & \underline{3} & & \underline{x} & \underline{x} & \underline{x} \\ & & 32 & 31 & 30 & & 32 & 31 & 30 \end{array}$	Restorable Teeth	$\begin{array}{ccccccc} & & 1 & \underline{2} & \underline{3} & & x \\ & & \underline{32} & \underline{31} & \underline{30} & & \underline{32} & \underline{31} & \underline{30} \end{array}$	Non- restorable Teeth	$\begin{array}{ccccccc} & & x & & & & x \\ & & \underline{1} & \underline{2} & \underline{3} & & \underline{x} & \underline{x} & \underline{x} \\ & & 32 & 31 & 30 & & 32 & 31 & 30 \end{array}$	Missing Teeth	$\begin{array}{ccccccc} & & x & x & x & & \\ & & \underline{1} & \underline{2} & \underline{3} & & \\ & & 32 & 31 & 30 & & \end{array}$	Replaced by Dentures	$\begin{array}{ccccccc} & & (& x &) & & \\ & & \underline{1} & \underline{2} & \underline{3} & & \\ & & 32 & 31 & 30 & & \end{array}$	Fixed Partial Dentures		

19. TEST RESULTS (Copies of results are preferred as attachments)

A. URINALYSIS: (1) SPECIFIC GRAVITY		B. CHEST X-RAY OR PPD <i>(Place, date, film number and result)</i>	
(2) URINE ALBUMIN	(4) MICROSCOPIC		
(3) URINE SUGAR			
C. SYPHILIS SEROLOGY <i>(Specify test used and results)</i>	D. EKG	E. BLOOD TYPE AND RH FACTOR	F. OTHER TESTS

NAME	IDENTIFICATION NUMBER	NO. OF SHEETS ATTACHED
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MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR HAIR	23. COLOR EYES	24. BUILD: <input type="checkbox"/> SLENDER <input type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESE	25. TEMPERATURE
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26. BLOOD PRESSURE <i>(Arm at heart level)</i>				27. PULSE <i>(Arm at heart level)</i>			
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A. SITTING	SYS. DIAS.	B. RECUM-BENT DIAS.	SYS. DIAS.	C. STANDING <i>(5 mins.)</i> DIAS.	A. SITTING	B. RECUMBENT	C. STANDING <i>(3 MINS)</i>	D. AFTER EXERCISE	E. 2 MINS. AFTER
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28. DISTANT VISION			29. REFRACTION			30. NEAR VISION		
RIGHT 20/	CORR. TO 20/	BY	S.	CX	CORR. TO	BY	CORR. TO	BY
LEFT 20/	CORR. TO 20/	BY	S.	CX	CORR. TO	BY	CORR. TO	BY

31. HETEROPHORIA *(Specify distance)*

ESO	EXO	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD
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32. ACCOMMODATION		33. COLOR VISION <i>(Test used and result)</i>				34. DEPTH PERCEPTION <i>(Test used and score)</i>		UNCORRECTED										
RIGHT	LEFT					CORRECTED												
35. FIELD OF VISION		36. NIGHT VISION <i>(Test used and score)</i>				37. RED LENS TEST		38. INTRAOCULAR TENSION										
RIGHT	LEFT							RIGHT	LEFT									
39. HEARING		40. AUDIOMETER				41. PSYCHOLOGICAL AND PSYCHOMOTOR <i>(Tests used and scores)</i>												
RIGHT WV	/15 SV									/15	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192
LEFT WV	/15 SV									/15	RIGHT	LEFT						

42. NOTES *(Continued)* AND SIGNIFICANT OR INTERVAL HISTORY

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers)*

44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED <i>(Specify)</i>	45A. PHYSICAL PROFILE					
	P	U	L	H	E	S

46. EXAMINEE <i>(Check)</i> A. <input type="checkbox"/> IS QUALIFIED FOR B. <input type="checkbox"/> IS NOT QUALIFIED FOR	45B. PHYSICAL CATEGORY
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47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER	A	B	C	E
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48. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
49. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN <i>(Indicate which)</i>	SIGNATURE
51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE