

MEDICAL RECORD	REPORT OF MEDICAL EXAMINATION	DATE OF EXAM
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1. LAST NAME - FIRST NAME - MIDDLE NAME		2. IDENTIFICATION NUMBER		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 <input type="checkbox"/> HISPANIC <input type="checkbox"/> ASIAN/PACIFIC WHITE BLACK 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 36</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 41</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;"> $\begin{array}{ccccccc} & 0 & & / & & X & \\ \hline 1 & 2 & 3 & \text{Restorable} & 1 & 2 & 3 & \text{Non-} & X & X & X & \text{Replaced} & (X) & \text{Fixed} \\ 32 & 31 & 30 & \text{Teeth} & 32 & 31 & 30 & \text{restorable} & 1 & 2 & 3 & \text{by} & 1 & 2 & 3 & \text{Partial} \\ & 0 & & & & / & & \text{Teeth} & 32 & 31 & 30 & \text{Dentures} & 32 & 31 & 30 & \text{Dentures} \\ & & & & & & & & X & X & X & & (X) & & & \end{array}$ </td> <td style="width:30%; vertical-align: top;"> REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES </td> </tr> <tr> <td style="text-align: center;"> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black;"> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">R I G H T</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">4</td> <td style="text-align: center;">5</td> <td style="text-align: center;">6</td> <td style="text-align: center;">7</td> <td style="text-align: center;">8</td> <td style="border-right: 1px solid black;"></td> <td style="text-align: center;">9</td> <td style="text-align: center;">10</td> <td style="text-align: center;">11</td> <td style="text-align: center;">12</td> <td style="text-align: center;">13</td> <td style="text-align: center;">14</td> <td style="text-align: center;">15</td> <td style="text-align: center;">16</td> <td style="text-align: center;">L E F T</td> </tr> <tr> <td style="border-right: 1px solid black;"></td> <td style="text-align: center;">32</td> <td style="text-align: center;">31</td> <td style="text-align: center;">30</td> <td style="text-align: center;">29</td> <td style="text-align: center;">28</td> <td style="text-align: center;">27</td> <td style="text-align: center;">26</td> <td style="text-align: center;">25</td> <td style="border-right: 1px solid black;"></td> <td style="text-align: center;">24</td> <td style="text-align: center;">23</td> <td style="text-align: center;">22</td> <td style="text-align: center;">21</td> <td style="text-align: center;">20</td> <td style="text-align: center;">19</td> <td style="text-align: center;">18</td> <td style="text-align: center;">17</td> <td style="border-right: 1px solid black;"></td> </tr> </table> </td> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;"></td> </tr> </table> </td> <td style="width:30%;"></td> </tr> </table>	$\begin{array}{ccccccc} & 0 & & / & & X & \\ \hline 1 & 2 & 3 & \text{Restorable} & 1 & 2 & 3 & \text{Non-} & X & X & X & \text{Replaced} & (X) & \text{Fixed} \\ 32 & 31 & 30 & \text{Teeth} & 32 & 31 & 30 & \text{restorable} & 1 & 2 & 3 & \text{by} & 1 & 2 & 3 & \text{Partial} \\ & 0 & & & & / & & \text{Teeth} & 32 & 31 & 30 & \text{Dentures} & 32 & 31 & 30 & \text{Dentures} \\ & & & & & & & & X & X & X & & (X) & & & \end{array}$	REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES	<table style="width:100%; 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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	25. TEMPERATURE
				<input type="checkbox"/> SLENDER <input type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESE	

26. BLOOD PRESSURE (Arm at heart level)					27. PULSE (Arm at heart level)					
A. SITTING	SYS.	B. RECUM-BENT	SYS.	C. STANDING (5 mins.)	SYS.	A. SITTING	B. RECUMBENT	C. STANDING (3 mins)	D. AFTER EXERCISE	E. 2 MINS. AFTER
	DIAS.	DIAS.	DIAS.	DIAS.	DIAS.					

28. DISTANT VISION			29. REFRACTION			30. NEAR VISION		
RIGHT 20/	CORR. TO 20/	BY	S.	CX	CORR. TO	BY		
LEFT 20/	CORR. TO 20/	BY	S.	CX	CORR. TO	BY		

31. HETEROPHORIA (Specify distance)									
ESO	EXO	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD		

32. ACCOMMODATION			33. COLOR VISION (Test used and result)					34. DEPTH PERCEPTION (Test used and score)		UNCORRECTED				
RIGHT	LEFT									CORRECTED				
35. FIELD OF VISION			36. NIGHT VISION (Test used and score)					37. RED LENS TEST		38. INTRAOCULAR TENSION				
RIGHT	LEFT									RIGHT	LEFT			
39. HEARING			40. AUDIOMETER							41. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)				
RIGHT W/V	/15SV	/15		250	500	1000	2000	3000	4000	6000	8000			
				256	512	1024	2048	2896	4096	6144	8192			
LEFT W/V	/15SV	/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 (Specify)	45A. PHYSICAL PROFILE					
	P	U	L	H	E	S

46. EXAMINEE (Check)	45B. PHYSICAL CATEGORY			
A. <input type="checkbox"/> IS QUALIFIED FOR				
B. <input type="checkbox"/> IS NOT QUALIFIED FOR				

47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER	A	B	C	E

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 (Indicate which)	SIGNATURE
51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE