

<b>MEDICAL RECORD</b>		<b>REPORT OF MEDICAL EXAMINATION</b>			DATE OF EXAM
1. LAST NAME - FIRST NAME - MIDDLE NAME			2. IDENTIFICATION NO.		3. GRADE AND COMPONENT OR POSITION
4. HOME ADDRESS (Number, street or RFD, city or town, state and ZIP code)			5. EMERGENCY CONTACT (Name and address of contact)		
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		

**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 (Over 40 or clinically indicated)	
	B. EARS-GENERAL (INTERNAL CANALS) (Auditory acuity under items 39 and 40)			P. TESTICULAR	
	C. DRUMS			Q. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Hemocult Results)	
	D. NOSE			R. ENDOCRINE SYSTEM	
	E. SINUSES			S. G-U SYSTEM	
	F. MOUTH AND THROAT			T. UPPER EXTREMITIES (Strength, range of motion)	
	G. EYES-GENERAL (Visual acuity and refraction under items 28, 29, and 36)			U. FEET	
	H. OPHTHALMOSCOPIC			V. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
	I. PUPILS (Equality and reaction)			W. SPINE, OTHER MUSCULALSKELETAL	
	J. OCULAR MOTILITY (Associated parallel movements nystagmus)			X. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	K. LUNGS AND CHEST			Y. SKIN, LYMPHATICS	
	L. HEART (Thrust, size, rythm, sounds)			Z. NEUROLOGIC (Equilibrium tests under item 41)	
	M. VASCULAR SYSTEM (Varicosities, etc.)			AA. PSYCHIATRIC (Specify and personality deviation)	
	N. ABDOMEN AND VISCERA (Include hernia)			BB. BREASTS	
				CC. PELVIC (Females only)	

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 (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">0</td> <td style="text-align: center;">/</td> <td style="text-align: center;">Non-</td> <td style="text-align: center;">x</td> <td style="text-align: center;">x x x</td> <td style="text-align: center;">( x )</td> <td style="text-align: center;">Fixed</td> </tr> <tr> <td style="text-align: center;">1 2 3</td> <td style="text-align: center;">1 2 3</td> <td style="text-align: center;">Restorable</td> <td style="text-align: center;">1 2 3</td> <td style="text-align: center;">Missing</td> <td style="text-align: center;">1 2 3</td> <td style="text-align: center;">Replaced</td> </tr> <tr> <td style="text-align: center;">32 31 30</td> <td style="text-align: center;">32 31 30</td> <td style="text-align: center;">Teeth</td> <td style="text-align: center;">32 31 30</td> <td style="text-align: center;">Teeth</td> <td style="text-align: center;">32 31 30</td> <td style="text-align: center;">by dentures</td> </tr> <tr> <td style="text-align: center;">0</td> <td style="text-align: center;">/</td> <td style="text-align: center;">Teeth</td> <td style="text-align: center;">x</td> <td style="text-align: center;">x x x</td> <td style="text-align: center;">( x )</td> <td style="text-align: center;">Partial</td> </tr> <tr> <td style="text-align: center;">R</td> <td style="text-align: center;">1 2 3</td> <td style="text-align: center;">4 5 6</td> <td style="text-align: center;">7 8</td> <td style="text-align: center;">9 10 11</td> <td style="text-align: center;">12 13 14</td> <td style="text-align: center;">15 16</td> </tr> <tr> <td style="text-align: center;">I</td> <td style="text-align: center;">32 31 30</td> <td style="text-align: center;">29 28 27</td> <td style="text-align: center;">26 25</td> <td style="text-align: center;">24 23 22</td> <td style="text-align: center;">21 20 19</td> <td style="text-align: center;">18 17</td> </tr> <tr> <td style="text-align: center;">G</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">H</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">T</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	0	/	Non-	x	x x x	( x )	Fixed	1 2 3	1 2 3	Restorable	1 2 3	Missing	1 2 3	Replaced	32 31 30	32 31 30	Teeth	32 31 30	Teeth	32 31 30	by dentures	0	/	Teeth	x	x x x	( x )	Partial	R	1 2 3	4 5 6	7 8	9 10 11	12 13 14	15 16	I	32 31 30	29 28 27	26 25	24 23 22	21 20 19	18 17	G							H							T							<p>REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES</p>
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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 (Place, date, film number and result)	
(2) URINE ALBUMIN		4. MICROSCOPIC	
(3) URINE SUGAR			
C. SYPHILIS SEROLOGY (Specify test used and results)		D. EKG	E. BLOOD TYPE AND RH FACTOR
		F. OTHER TESTS	

NAME	IDENTIFICATION NO.	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	26. TEMPERATURE
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26. BLOOD PRESSURE (Arm at heart level)				27. PULSE (Arm at heart level)						
A. SITTING	SYS. DIAS.	B. RECUMBENT	SYS. DIAS.	C. STANDING (5 min.)	SYS. DIAS.	A. SITTING	B. RECUMBENT	C. STANDING (3 mins.)	D. AFTER EXERCISE	E. 2 MINS AFTER

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)

FSO	EXO	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD
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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 WV	/15	SV	/15		250	500	1000	2000	3000			4000	6000	8000
				RIGHT	256	512	1024	2048	2896			4096	6144	8192
LEFT WV	/15	SV	/15	LEFT										

42. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

(Use additional sheets if necessary)

44. 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) A. <input type="checkbox"/> IS QUALIFIED FOR B. <input type="checkbox"/> IS NOT QUALIFIED FOR	45B. PHYSICAL CATEGORY					
	A	B	C	E		
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