REPORT OF MEDICAL EXAMINATION

1. DATE OF EXAMINATION (YYYYMMDD)	2. SOCIAL SECURITY NUMBER
20090818	123-45-6789

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code)	5. HOME TELEPHONE NUMBER (Include Area Code)
PUBLIC, JOHN Q.	123 MAIN STREET OCEANSIDE, CA 92057	760-555-1234

6. GRADE	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX	10.a. RACIAL CATEGORY (X one or more)	b. ETHNIC CATEGORY
E-5	19870318	22	[ ] Female [X] Male	[ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American [X] White [ ] Native Hawaiian or Other Pacific Islander [ ] Decline to Respond	[ ] Hispanic/Latino [X] Not Hispanic/Latino [ ] Decline to Respond

11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY	b. CIVILIAN	12. AGENCY (Non-Service Members Only)	13. ORGANIZATION UNIT AND UIC/CODE
	N/A	N/A	9TH BN, 5TH LAR/99999

14.a. RATING OR SPECIALTY (Aviators Only)	b. TOTAL FLYING TIME	c. LAST SIX MONTHS

15.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION	16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include ZIP Code)
[ ] Army [ ] Coast Guard [ ] Navy [ ] Marine Corps [ ] Air Force	[ ] Active Duty [ ] Reserve [ ] National Guard	[ ] Enlistment [ ] Medical Board [X] Other NSW/SO [ ] Commission [ ] Retirement [ ] Retention [ ] U.S. Service Academy [ ] Separation [ ] ROTC Scholarship Program	9TH BN, 5TH LAR BAS BLDG 51516 Camp Pendleton, CA 92055

CLINICAL EVALUATION *(Check each item in appropriate column. Enter "NE" if not evaluated.)*

	Normal	Abnorm	NE
17. Head, face, neck, and scalp	X		
18. Nose	X		
19. Sinuses	X		
20. Mouth and throat	X		
21. Ears - General *(Int. and ext. canals/Auditory acuity under item 71)*	X		
22. Drums *(Perforation)*	X		
23. Eyes - General *(Visual acuity and refraction under items 61 - 63)*	X		
24. Ophthalmoscopic	X		
25. Pupils *(Equality and reaction)*	X		
26. Ocular motility *(Associated parallel movements, nystagmus)*	X		
27. Heart *(Thrust, size, rhythm, sounds)*	X		
28. Lungs and chest *(Include breasts)*	X		
29. Vascular system *(Varicosities, etc.)*	X		
30. Anus and rectum *(Hemorrhoids, Fistulae) (Prostate if indicated)*	X		
31. Abdomen and viscera *(Include hernia)*	X		
32. External genitalia *(Genitourinary)*	X		
33. Upper extremities	X		
34. Lower extremities *(Except feet)*	X		
35. Feet *(See Item 35 Continued)*	X		
36. Spine, other musculoskeletal	X		
37. Identifying body marks, scars, tattoos		X	
38. Skin, lymphatics	X		
39. Neurologic	X		
40. Psychiatric *(Specify any personality deviation)*	X		
41. Pelvic *(Females only)*			X
42. Endocrine	X		

43. DENTAL DEFECTS AND DISEASE *(Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in Item 44.)*

[X] Acceptable
[ ] Not Acceptable Class _____

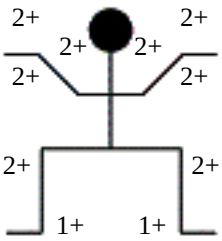
44. NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)*

22. Valsalva SAT / UNSAT
37. Circ._X_yes___no
Scars/Tattoos:
Tattoo L deltoid 2"x3"
RLQ scar 3" diagonal

39. A&Ox__3_/3, Recall __3_/3, Serial 7's WNL_

CN 2-12: grossly intact

Strength: UE __5_/5
LE __5_/5



Sensory: intact to light touch throughtout
Cerebellar:
_nl_Finger-to-nose
_nl_Heel-to-shin
neg_Romberg
_nl_Gait

35. FEET *(Continued) (Circle category)*

Normal Arch	Mild	Asymptomatic
Pes Cavus	Moderate	
Pes Planus	Severe	Symptomatic

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LABORATORY FINDINGS

45. URINALYSIS	a. Albumin	46. URINE HCG	47. H/H	48. BLOOD TYPE
21JUL09 SG 1.120	Neg			O POS
	b. Sugar Neg			

TESTS	RESULTS	HIV SPECIMEN ID LABEL	DRUG TEST SPECIMEN ID LABEL
49. HIV	21MAR2008 - Neg		
50. DRUGS			
51. ALCOHOL			
52. OTHER			
a. PAP SMEAR			
b.			
c.			

MEASUREMENTS AND OTHER FINDINGS

53. HEIGHT	54. WEIGHT	55. MIN WGT - MAX WGT MAX BF %	56. TEMPERATURE	57. PULSE
71	175 lbs.		98.6	66

58. BLOOD PRESSURE			59. RED/GREEN *(Army Only)*	60. OTHER VISION TEST
a. 1ST	b. 2ND	c. 3RD		
SYS. 120	SYS.	SYS.		
DIAS. 80	DIAS.	DIAS.		

61. DISTANT VISION	62. REFRACTION BY AUTOREFRACTION OR MANIFEST	63. NEAR VISION
Right 20/ 20 Corr. to 20/	By S. CX	Right 20/ 20 Corr. to 20/ by
Left 20/ 20 Corr. to 20/	By S. CX	Left 20/ 20 Corr. to 20/ by

64. HETEROPHORIA *(Specify distance)*

ES ° EX ° R.H. L.H. Prism div. Prism Conv CT NPR PD

65. ACCOMMODATION		66. COLOR VISION *(Test used and result)*	67. DEPTH PERCEPTION *(Test used and score)* AFVT	
Right	Left	PIP PASS 14 /14	Uncorrected	Corrected

68. FIELD OF VISION	69. NIGHT VISION *(Test used and score)*	70. INTRAOCULAR TENSION	
120 DEG	NIBH	O.D.	O.S.

71a. AUDIOMETER Unit Serial Number 21139

Date Calibrated *(YYYYMMDD)* 20080908

HZ	500	1000	2000	3000	4000	6000
Right	0	0	5	5	10	15
Left	0	0	0	-5	10	5

71b. Unit Serial Number

Date Calibrated *(YYYYMMDD)*

HZ	500	1000	2000	3000	4000	6000
Right						
Left						

72a. READING ALOUD TEST SAT UNSAT

72b. VALSALVA SAT UNSAT

73. NOTES *(Continued)* **AND SIGNIFICANT OR INTERVAL HISTORY** *(Use additional sheets if necessary.)*

DATE: 21JUL09
WBC 6.5
HGB 14.4
HCT 44.2
PLT 245

DATE: 21JUL09
TCHOL 206
HDL 51
LDL 114
TG 110
GLUC 89

DATE: 18APR05
G6PD NORMAL
SICKLE CELL NEGATIVE

DATE: 21JUL09
HEP C NEGATIVE

DATE: 21JUL09 EXAM #: 09073456
CXR - No acute cardiopulmonary disease (NACPD)

DATE: 21JUL09
EKG - NSR

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74.a. EXAMINEE/APPLICANT *(check one)*

[X] IS QUALIFIED FOR SERVICE (PQ) / NPQ NSW/SO DUTY

[ ] IS NOT QUALIFIED FOR SERVICE

75. I have been advised of my disqualifying condition.

a. SIGNATURE OF EXAMINEE

b. DATE *(YYYYMMDD)*

b. PHYSICAL PROFILE

P	U	L	H	E	S	X	PROFILER INITIALS	DATE *(YYYYMMDD)*

76. SIGNIFICANT OR DISQUALIFYING DEFECTS

ITEM NO.	MEDICAL CONDITION/DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE *(YYYYMMDD)*	QUALIFIED	DISQUALIFIED	EXAMINER INITIALS	WAIVER RECEIVED	
								SERVICE	DATE *(YYYYMMDD)*

77. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers) (Use additional sheets if necessary.)*

37 - MARKS, SCARS, TATTOOS (MST) - NCD
73 - MILD DYSLIPIDEMIA - NCD

78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify) (Use additional sheets if necessary.)*

79. MEPS WORKLOAD *(For MEPS use only)*

WKID	ST	DATE *(YYYYMMDD)*	INITIAL	WKID	ST	DATE *(YYYYMMDD)*	INITIAL

80. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	PHYSICIAN'S SIGNATURE

81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE
82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER SMITH, ROBERT A., LT, MC (GMO), USN	**b. SIGNATURE** R. Smith
83.a. TYPED OR PRINTED NAME OF (DENTIST) OR PHYSICIAN *(Indicate which)* JONES, WALTER A., LCDR, DC, USN	**b. SIGNATURE** Walter Jones, DDS
84.a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY	**b. SIGNATURE**

85. This examination has been administratively reviewed for completeness and accuracy.

a. SIGNATURE	b. GRADE	c. DATE *(YYYYMMDD)*

86. WAIVER GRANTED *(If yes, date and by whom)*

[ ] YES

[ ] NO

87. NUMBER OF ATTACHED SHEETS