

REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

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PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. Subtitle A, General Military Law, Part II, Personnel (Chapter 31, Enlistments and Chapter 33, Original Appointments of Regular Officers in Grades Above Warrant Officer Grades); 10 U.S.C. 3013, Secretary of the Army; 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 8013, Secretary of the Air Force; DoD Directive (DoDD) 1145.02E, United States Military Entrance Processing Command (USMEPCOM); DoD Instruction (DoDI) 1304.02, Accession Processing Data Collection Forms; DoDI 1304.12E, DoD Military Personnel Accession Testing Programs; DoDI 1304.26, Qualification Standards for Enlistment, Appointment and Induction; DoDI 1332.18, Disability Evaluation System; DoDI 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services; DoD Manual 1145.02, Military Entrance Processing Station (MEPS); USMEPCOM Regulation 680-3, Entrance Processing and Reporting System Management; and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): To assist DoD physicians in making determinations as to acceptability of applicants for military service and to verify disqualify medical condition(s) noted on the accessions medical history report (DD2807-2). This form may also be used by Medical Evaluation Boards to determine the medical fitness of a current member and if separation is warranted.

ROUTINE USE(S): Disclosure of records are generally permitted under 5 U.S.C. 522a(b) of the Privacy Act of 1974, as amended. Pursuant to 5 U.S.C. 522a(b)(3), records may be disclosed as a routine use to Federal, State and local health departments for compliance with public health communicable disease reporting laws in accordance with 42 U.S.C. 264. A complete list of routine uses may be found in the applicable System of Records Notice, United States Military Entrance Processing Command (USMEPCOM) Integrated Resource System (USMIRS), A0601-270 at: <https://www.federalregister.gov/documents/2021/04/21/2021-08286/privacy-act-of-1974-system-of-records>.

DISCLOSURE: Voluntary; however, failure to provide the requested information may result in an inability to process your application for enlistment or appointment in the Armed Forces. For current Armed Forces members, failure to provide the requested information may result in being placed in non-deployable status.

Additional system of records notices:

Physical/Medical Evaluation Records

Army: <https://dpcl.d.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569965/a0040-3b-dasg/>Navy: <https://dpcl.d.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570339/nm01850-2/>Air Force: <https://dpcl.d.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569861/>

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2.a SOCIAL SECURITY NO.	b. DoD ID NO. (If applicable)	3. TODAY'S DATE (YYYYMMDD)
4.a. HOME ADDRESS (Stress, Apartment No., City, State, and ZIP Code)		5. EXAMINING LOCATION AND ADDRESS (Include Zip Code)	
b. HOME TELEPHONE (Include Area Code)			
c. EMAIL ADDRESS			

X ALL APPLICABLE BOXES:			7.a. POSITION (Title, Grade, Component)
6.a. SERVICE	6.b. COMPONENT	6.c. PURPOSE OF EXAMINATION	b. USUAL OCCUPATION
☐ Army ☐ Navy ☐ Marine Corps ☐ Air Force	☐ Coast Guard ☐ USPHS ☐ Space Force ☐ NOAA	☐ Regular ☐ Reserve ☐ National Guard ☐ Retention ☐ Separation ☐ Medical Board ☐ Retirement	☐ Other (Specify)
8. CURRENT MEDICATIONS (Prescription and Over-the-Counter)			9. ALLERGIES (Including insect bites/stings, foods, medicine, or other substance)

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	12. (Continued)	YES	NO
10.a. Tuberculosis	☐	☐	f. Foot trouble (e.g., pain, corns, bunions, etc.)	☐	☐
b. Lived with someone who had tuberculosis	☐	☐	g. Impaired use of arms, legs, hands, or feet	☐	☐
c. Coughed up blood	☐	☐	h. Swollen or painful joint(s)	☐	☐
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	☐	☐	i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	☐	☐
e. Shortness of breath	☐	☐	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	☐	☐
f. Bronchitis	☐	☐	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts, or orthotics, etc.	☐	☐
g. Wheezing or problems with wheezing	☐	☐	l. Bone, joint, or other deformity	☐	☐
h. Been prescribed or used an inhaler	☐	☐	m. Plate(s), screw(s), rod(s), or pin(s) in any bone	☐	☐
i. A chronic cough or cough at night	☐	☐	n. Broken bone(s) (cracked or fractured)	☐	☐
j. Sinusitis	☐	☐	13.a. Frequent indigestion or heartburn	☐	☐
k. Hay fever	☐	☐	b. Stomach, liver, intestinal trouble, or ulcer	☐	☐
l. Chronic or frequent colds	☐	☐	c. Gall bladder trouble or gallstones	☐	☐
11.a. Severe tooth or gum trouble	☐	☐	d. Jaundice or hepatitis (liver disease)	☐	☐
b. Thyroid trouble or goiter	☐	☐	e. Rupture/hernia	☐	☐
c. Eye disorder or trouble	☐	☐	f. Rectal disease, hemorrhoids, or blood from the rectum	☐	☐
d. Ear, nose, or throat trouble	☐	☐	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	☐	☐
e. Loss or vision in either eye	☐	☐	h. Frequent or painful urination	☐	☐
f. Worn contact lenses or glasses	☐	☐	i. High or low blood sugar	☐	☐
g. A hearing loss or wear a hearing aid	☐	☐	j. Kidney stone or blood in urine	☐	☐
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	☐	☐	k. Sugar or protein in urine	☐	☐
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	☐	☐	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	☐	☐
b. Arthritis, rheumatism, or bursitis	☐	☐	14.a. Adverse reaction to serum, food, insect stings, or medicine	☐	☐
c. Recurrent back pain or any back problem	☐	☐	b. Recent unexplained gain or loss of weight	☐	☐
d. Numbness or tingling	☐	☐	c. Currently in good health (If no, explain in Item 29 on Page 2.)	☐	☐
e. Loss of finger or toe	☐	☐	d. Tumor, growth, cyst, or cancer	☐	☐

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER <i>(If applicable)</i>
Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.		

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO		YES	NO
15.a. Dizziness or fainting spells	☐	☐	19. Have you been refused employment, or been unable to hold a job or stay in school because of:		
b. Frequent or severe headache	☐	☐	a. Sensitivity to chemicals, dust, sunlight, etc.	☐	☐
c. A head injury, memory loss or amnesia	☐	☐	b. Inability to perform certain motions	☐	☐
d. Paralysis	☐	☐	c. Inability to stand, sit, kneel, lie down, etc.	☐	☐
e. Seizures, convulsions, epilepsy, or fits	☐	☐	d. Other medical reasons <i>(If yes, give reasons.)</i>	☐	☐
f. Car, train, sea, or air sickness	☐	☐	20. Have you ever been treated in an Emergency Room? <i>(If yes, for what?)</i>	☐	☐
g. A period of unconsciousness or concussion	☐	☐	21. Have you ever been a patient in any type of hospital? <i>(If yes, specify when, where, why, and name of doctor and complete address of hospital.)</i>	☐	☐
h. Meningitis, encephalitis, or other neurological problems	☐	☐	22. Have you ever had, or have you been advised to have any operations or surgery? <i>(If yes, describe and give age at which occurred.)</i>	☐	☐
16.a. Rheumatic fever	☐	☐	23. Have you ever had any illness or injury other than those already noted? <i>(If yes, specify when, where, and give details.)</i>	☐	☐
b. Prolonged bleeding <i>(as after an injury or tooth extraction, etc.)</i>	☐	☐	24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? <i>(If yes, give complete address of doctor, hospital, clinic, and details.)</i>	☐	☐
c. Pain or pressure in the chest	☐	☐	25. Have you ever been rejected for military service for any reason? <i>(If yes, give date and reason for rejection.)</i>	☐	☐
d. Palpitation, pounding heart or abnormal heartbeat	☐	☐	26. Have you ever been discharged from military service for any reason? <i>(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)</i>	☐	☐
e. Heart trouble or murmur	☐	☐	27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? <i>(If yes, specify what kind, granted by whom, and what amount, when, why.)</i>	☐	☐
f. High or low blood pressure	☐	☐	28. Have you ever been denied life insurance?	☐	☐
17.a. Nervous trouble of any sort <i>(anxiety or panic attacks)</i>	☐	☐			
b. Habitual stammering or stuttering	☐	☐			
c. Loss of memory or amnesia, or neurological symptoms	☐	☐			
d. Frequent trouble sleeping	☐	☐			
e. Received counseling of any type	☐	☐			
f. Depression or excessive worry	☐	☐			
g. Been evaluated or treated for a mental condition	☐	☐			
h. Attempted suicide	☐	☐			
i. Used illegal drugs or abused prescription drugs	☐	☐			
18. FEMALES ONLY. Have you ever had or do you now have:	☐	☐			
a. Treatment for a gynecological (female) disorder	☐	☐			
b. A change of menstrual pattern	☐	☐			
c. Any abnormal PAP smears	☐	☐			
d. First day of last menstrual period (YYYYMMDD)					
e. Date of last PAP smear (YYYYMMDD)					
29. EXPLANATION OF "YES" ANSWER(S) <i>(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)</i>					

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER <i>(If applicable)</i>
30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA <i>(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)</i>		
a. COMMENTS		
b. TYPED OR PRINTED NAME OF EXAMINER <i>(Last, First, Middle Initial)</i>	c. SIGNATURE	d. DATE SIGNED <i>(YYYYMMDD)</i>