REPORT OF MEDICAL HISTORY

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

OMB No. 0704-0413
OMB approval expires 20280131

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://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569965/a0040-3b-dasg/
Navy: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570339/nm01850-2/
Air Force: https://dpcld.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:

6.a. SERVICE
- [ ] Army
- [ ] Coast Guard
- [X] Navy
- [ ] USPHS
- [ ] Marine Corps
- [ ] Space Force
- [ ] Air Force
- [ ] NOAA

b. COMPONENT
- [ ] Regular
- [ ] Reserve
- [ ] National Guard

c. PURPOSE OF EXAMINATION
- [ ] Retention
- [ ] Other *(Specify)*
- [ ] Separation
- [ ] Medical Board
- [ ] Retirement

7.a. POSITION *(Title, Grade, Component)*

b. USUAL OCCUPATION

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
10.a. Tuberculosis	◯	◯
b. Lived with someone who had tuberculosis	◯	◯
c. Coughed up blood	◯	◯
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	◯	◯
e. Shortness of breath	◯	◯
f. Bronchitis	◯	◯
g. Wheezing or problems with wheezing	◯	◯
h. Been prescribed or used an inhaler	◯	◯
i. A chronic cough or cough at night	◯	◯
j. Sinusitis	◯	◯
k. Hay fever	◯	◯
l. Chronic or frequent colds	◯	◯
11.a. Severe tooth or gum trouble	◯	◯
b. Thyroid trouble or goiter	◯	◯
c. Eye disorder or trouble	◯	◯
d. Ear, nose, or throat trouble	◯	◯
e. Loss or vision in either eye	◯	◯
f. Worn contact lenses or glasses	◯	◯
g. A hearing loss or wear a hearing aid	◯	◯
h. Surgery to correct vision *(RK, PRK, LASIK, etc.)*	◯	◯
12.a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)*	◯	◯
b. Arthritis, rheumatism, or bursitis	◯	◯
c. Recurrent back pain or any back problem	◯	◯
d. Numbness or tingling	◯	◯
e. Loss of finger or toe	◯	◯

12. *(Continued)*	YES	NO
f. Foot trouble *(e.g., pain, corns, bunions, etc.)*	◯	◯
g. Impaired use of arms, legs, hands, or feet	◯	◯
h. Swollen or painful joint(s)	◯	◯
i. Knee trouble *(e.g., locking, giving out, pain or ligament injury, etc.)*	◯	◯
j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	◯	◯
k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts, or orthotics, etc.	◯	◯
l. Bone, joint, or other deformity	◯	◯
m. Plate(s), screw(s), rod(s), or pin(s) in any bone	◯	◯
n. Broken bone(s) *(cracked of fractured)*	◯	◯
13.a. Frequent indigestion or heartburn	◯	◯
b. Stomach, liver, intestinal trouble, or ulcer	◯	◯
c. Gall bladder trouble or gallstones	◯	◯
d. Jaundice or hepatitis *(liver disease)*	◯	◯
e. Rupture/hernia	◯	◯
f. Rectal disease, hemorrhoids, or blood from the rectum	◯	◯
g. Skin diseases *(e.g. acne, eczema, psoriasis, etc.)*	◯	◯
h. Frequent or painful urination	◯	◯
i. High or low blood sugar	◯	◯
j. Kidney stone or blood in urine	◯	◯
k. Sugar or protein in urine	◯	◯
l. Sexually transmitted disease *(syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)*	◯	◯
14.a. Adverse reaction to serum, food, insect stings, or medicine	◯	◯
b. Recent unexplained gain or loss of weight	◯	◯
c. Currently in good health *(If no, explain in Item 29 on Page 2.)*	◯	◯
d. Tumor, growth, cyst, or cancer	◯	◯

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER *(If applicable)*

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
15.a. Dizziness or fainting spells	◯	◯
b. Frequent or severe headache	◯	◯
c. A head injury, memory loss or amnesia	◯	◯
d. Paralysis	◯	◯
e. Seizures, convulsions,epilepsy, or fits	◯	◯
f. Car, train,sea,or air sickness	◯	◯
g. A period of unconsciousness or concussion	◯	◯
h. Meningitis, encephalitis, or other neurological problems	◯	◯
16.a. Rheumatic fever	◯	◯
b. Prolonged bleeding *(as after an injury or tooth extraction, etc.)*	◯	◯
c. Pain or pressure in the chest	◯	◯
d. Palpitation, pounding heart or abnormal heartbeat	◯	◯
e. Heart trouble or murmur	◯	◯
f. High or low blood pressure	◯	◯
17.a. Nervous trouble of any sort *(anxiety or panic attacks)*	◯	◯
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)*		

	YES	NO
19. Have you been refused employment, or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.	◯	◯
b. Inability to perform certain motions	◯	◯
c. Inability to stand, sit, kneel, lie down, etc.	◯	◯
d. Other medical reasons *(If yes, give reasons.)*	◯	◯
20. Have you ever been treated in an Emergency Room? *(If yes, for what?)*	◯	◯
21. Have you ever been a patient in any type of hospital? *(If yes, specify when, where,why, and name of doctor and complete address of hospital.*	◯	◯
22. Have you ever had, or have you been advised to have any operations or surgery? *(If yes, describe and give age at which occurred.)*	◯	◯
23. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*	◯	◯
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor,* hospital*, clinic, and details.)*	◯	◯
25. Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)*	◯	◯
26. Have you ever been discharged from military service for any reason? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)*	◯	◯
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? *(If yes, specify what kind, granted by whom, and what amount, when , why.)*	◯	◯
28. Have you ever been denied life insurance?	◯	◯

29. EXPLANATION OF "YES" ANSWER(S) *(Describe answer(s), give date(s) of problem, name of doctor(s)and/or* **hospital***(s), treatment given and current medical status.)*

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 *(If applicable)*

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(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.)*

a. COMMENTS

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*