Army Regulation 40–29 AFR 160-13 NAVMEDCOMINST 6120.2A CGCOMDTINST M6120.8B

Medical Service

MEDICAL EXAMINATION OF APPLICANTS FOR **UNITED STATES** SERVICE ACADEMIES. **RESERVE OFFICER TRAINING CORPS** (ROTC) SCHOLARSHIP **PROGRAMS**. **INCLUDING 2– AND 3–YEAR COLLEGE SCHOLARSHIP PROGRAMS (CSP)**, AND THE UNIFORMED SERVICES UNIVERSITY **OF THE HEALTH** SCIENCES (USUHS)

Headquarters Departments of the Army, the Air Force, the Navy, and the Transportation Washington, DC 20 October 1989

UNCLASSIFIED

SUMMARY of CHANGE

AR 40-29/AFR 160-13/NAVMEDCOMINST 6120.2A/CGCOMDTINST M6120.8B MEDICAL EXAMINATION OF APPLICANTS FOR UNITED STATES SERVICE ACADEMIES, RESERVE OFFICER TRAINING CORPS (ROTC) SCHOLARSHIP PROGRAMS, INCLUDING 2- AND 3-YEAR COLLEGE SCHOLARSHIP PROGRAMS (CSP), AND THE UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES (USUHS)

This revision--

- o clarifies procedures MTFs will follow when applicants arrive who are not scheduled by DODMERB (para2);
- o permits the use of DD Form 2492 as an exception to SF 93, Report of Medical History, which will be used to report a medical history to DODMERB (paras 5*a* and 9*b*);
- o advises examining facilities of the proper format for addressing medical correspondence to the DODMERB (para 5c);
- o includes remedial medical information as being prohibited from being mailed
 Certified or Registered Mail (para 5e(2)(c);
- o clarifies procedures examining physicians will follow when applicant must be hospitalized as part of the medical examination(para 6);
- o adds additional information about applicants requiring specialty
 consultations and laboratory procedures before their examinations (para 7);
- o redesignates DODMERB Form 6, Report of Dental Examination of DD Form 2480
 (para 9a); adds a list of abbreviations (atch 1);
- o adds an explanation and model entry for blood alcohol testing and urine drug screen (atch 2, item 29);
- o rescinds DD Form 2376, Supplemental Statement of Medical History.

Headquarters Departments of the Army, the Air Force, the Navy, and the Transportation Washington, DC

20 October 1989

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MEDICAL EXAMINATION OF APPLICANTS FOR UNITED STATES SERVICE ACADEMIES, **RESERVE OFFICER TRAINING CORPS (ROTC) SCHOLARSHIP PROGRAMS, INCLUDING 2–** AND 3-YEAR COLLEGE SCHOLARSHIP PROGRAMS (CSP), AND THE UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES (USUHS)

BY ORDER OF THE SECRETARIES OF THE AIR FORCE, THE ARMY, THE NAVY, AND DEPARTMENT OF TRANSPORTATION LARRY D WELCH Conoral USAE

OFFICIAL MILTON H. HAMILTON Administrative Assistant to the Secretary of the Army OFFICIAL WILLIAM O. NATIONS, Colonel, Director of Information Managemer and Administration		LARRY D. WELCH, General, USAF Chief of Staff CARL E. VUONO General, United States Army Chief of Staff OFFICIAL MICHAEL HUDGINS RADM, USPHS Chief. Office of Health and Safety US Coast Guard
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Applicability. This applies to all medical facility personnel who perform such medical

Services University of the Health Sciences

fected by the Privacy Act of 1974. Each form required by this regulation and which involves the Privacy Act either contains a Privacy Act Statement incorporated in the body of the document or is covered by DD Form 2005, Privacy Act Statement-Health Care

3434, intended for command level B. Navy: Ships and Stations Having Medical Department Personnel.

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Contents (Listed by paragraph and page number) General provisions: • 1, page 1 Authorized Applicants. • 2, *page 1* Where Examinations Will Be Performed. • 3, *page 1* Scheduling Notification to Examining Facilities. • 4, page 1 Completion and Disposition of Forms: • 5, page 1 Hospitalization of an Applicant. • 6, page 1 Civilian Consultation and Additional Evaluations. • 7, page 1 Direct Communications. • 8, page 2 Scope of Examination: • 9, page 2 Supply of Forms: • 10, page 2

Figure List

(USUHS).

- Figure 2-1: DD FORM 2351, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL EXAMINATION, page 4
- Figure 2-2: DD FORM 2351, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL EXAMINATION, page 5
- Figure 2-1: ITEM-BY-ITEM EXPLANATION FOR FILLING OUT DD FORM 2351, page 6
- Figure 3-1: DD FORM 2492, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL HISTORY-MALE, page 12
- Figure 3-2: DD FORM 2492 Reverse, MAR 87, page 13
- Figure 3-3: DD FORM 2492, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL history-FEMALE, page 14

*This pamphlet supersedes AFR 160-13/AR 405-29/NAVMEDCOMINST 6120.2/CGCOMDTINST M6120.8A, 30 June 1986.

AR 40-29/AFR 160-13/NAVMEDCOMINST 6120.2A/CGCOMDTINST M6120.8B • 20 October 1989

UNCLASSIFIED

Contents—Continued

- Figure 3-4: DD FORM 2492 Reverse, MAR 87, page 15
- Figure 3-5: DD FORM 2492, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL HISTORY. page 16
- Figure 3-6: DD FORM 2492 Reverse, MAR 87, page 17
- Figure 4-1: DD FORM 2480, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF DENTAL EXAMINATION, page 18
- Figure 4-2: DD FORM 2480 Reverse, NOV 86, page 19
- Figure 4-3: DD FORM 2480, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF DENTAL EXAMINATION, page 20
- Figure 4-4: DD FORM 2480 Reverse, NOV 86, page 21
- Figure 2-1: ITEM-BY-ITEM EXPLANATION FOR FILLING OUT DD FORM 2480, page 22
- Figure 5-1: DD FORM 2369, DOD MEDICAL EXAMINATION **REVIEW BOARD CYCLOPEGIC REFRACTION**, page 23
- Figure 5-2: DD FORM 2369 Reverse, MAYT 86, page 24
- Figure 6-1: DD FORM 2370, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) THREE-DAY BLOOD PRESSURE AND PULSE CHECK, page 25
- Figure 6-2: DD FORM 2370 Reverse, MAY 85, page 26
- Figure 7-1: DD FORM 2371, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) UPDATE OF APPLICANT'S MEDICAL EXAMINATION, page 27
- Figure 7-2: DD FORM 2371 Reverse, MAY 85, page 28
- Figure 8-1: DD FORM 2372, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF PRESENT HEALTH, page 29
- Figure 8-2: DD FORM 2372 Reverse, FEB 86, page 30
- Figure 9-1: DD FORM 2374, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) HEART MURMUR EVALUATION, page 31
- Figure 9-2: DD FORM 2374 Reverse, MAY 85, page 32
- Figure 10-1: DD FORM 2375, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) PULMONARY FUNCTION STUDIES, page 33
- Figure 10-2: DD FORM 2375 Reverse, MAY 85, page 34
- Figure 11-1: DD FORM 2377, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) RED/GREEN COLOR VISION TEST, page 35
- Figure 11-2: DD FORM 2375 Reverse, MAY 85, page 36
- Figure 12-1: DD FORM 2378, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY **REGARDING HEADACHES**, page 37
- Figure 12-2: DD FORM 2378 Reverse, MAY 85, page 38
- Figure 13-1: DD FORM 2379, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY **REGARDING HEAD INJURY**, page 39
- Figure 13-2: DD FORM 2379 Reverse, MAY 85, page 40
- Figure 14-1: DD FORM 2380, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING SLEEPWALKING, page 41
- Figure 14-2: DD FORM 2380 Reverse, MAY 85, page 42
- Figure 15-1: DD FORM 2381, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY **REGARDING MOTION SICKNESS**, page 43
- Figure 15-2: DD FORM 2381 Reverse, MAY 85, page 44
- Figure 16-1: DD FORM 2382, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING HAY FEVER, SINUSITIS, ASTHMA AND/OR ALLERGIES, page 45
- Figure 16-2: DD FORM 2382 Reverse, MAY 87, page 46
- Figure 17-1: DD FORM 2383, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF USE REGARDING MEDICATION, page 47
- Figure 17-2: DD FORM 2383 Reverse, MAY 85, page 48

- Figure 18-1: DD FORM 2489, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) FARNSWORTH LANTERN COLOR VISION TEST, page 49
- Figure 18-2: FARNSWORTH LANTERN COLOR VISION TEST - INSTRUCTIONS, page 50
- Figure 18-3: FARNSWORTH LANTERN COLOR VISION TEST, page 51
- Figure 18-4: FARNSWORTH LANTERN COLOR VISION TEST – INSTRUCTIONS, page 52
- Figure 19-1A: ADDITIONAL INSTRUCTIONS FOR PERFORMING MEDICAL TESTS, page 53
- Figure 19-1: ., page 53
- Figure 19-1B: ADDITIONAL INSTRUCTIONS FOR PERFORMING MEDICAL TESTS, page 53

Glossary

1. General provisions:

a. DD Forms 2351, DOD Medical Examination Review Board(DODMERB) Report of Medical Examination, and 2492, DOD Medical Examination Review Board (DODMERB) Report of Medical History, will be used to record medical examination results for the DODMERB only.They will not be used to record the results of medical examinations for any other Department of Defense (DoD) medical examination.

b. Every authorized applicant for a United States service academy (Military, Naval, Air Force, Coast Guard, Merchant Marine), ROTC Scholarship Program, or the USUHS, must take a complete medical examination as described in this regulation. Physicians or dentists must not terminate the examination if they not presumable disqualifying defects.

c. An examinee's medical status is determined by the DODMER-B.Examining physicians must not recommend waivers. They must not discuss with examinees how their medical findings affect examinee medical qualifications.

d. When the examinee wishes to present certificates from private physicians, or other forms of medical documentation, these documents must be sent to the address shown in paragraph 5c, with the complete examination. If an examinee wishes to submit evidence to rebut a medical disqualification by the DODMERB, the examinee must be advised to submit the material directly to the address in paragraph 5c. Such material should not be submitted to the examining physician, since that physician has not power to take further action.

e. The medical or dental examiner may, in the course of the medical examination or subsequent to it, discuss the findings of the examination with the examinee, parents, or guardians. The discussion must be limited to the medical significance of those findings, and recommendations must be related only to the examinee's health and well–being. The examiner must not relate the significance of any findings to the examinee's medical qualifications or disqualification for a service academy or ROTC scholarship program.

f. The medical or dental examiner must tell the examinee to seek further medical or dental care for any findings that may affect the examinee's health and well–being. As an example, if the blood pressure is elevated, the examinee must be told to see his or her own physician for further evaluation.

2. Authorized Applicants.

Medical examinations are conducted for only those applicants the DODMERB has officially scheduled (Medical Treatment Facility (MTF) will have been officially notified of applicants who have been scheduled at their facility). If unscheduled applicants call or appear in person and request a medical examination, the medical facility will refer them to the DODMERB. The DODMERB notifies applicants of the date and times their examinations have been scheduled.

3. Where Examinations Will Be Performed.

Applicants may take qualifying examinations only at those facilities the DODMERB designate.

4. Scheduling Notification to Examining Facilities.

The DODMERB sends each examining facility a list of applicants scheduled for examination, about 15 days before the examination date. On the examination day, each examining facility will mark a copy of the list to identify any applicants who did not report for examination, and return it to the DODMERB immediately.

5. Completion and Disposition of Forms:

a. The examining dentist completes DD Form 2480, DOD Medical Examination Review Board (DODMERB) Report of Dental Examination, according to paragraph 9*a*, and signs it. The examining physician completes DD Form 2351 (attachment 2), and DD Form 2492 (attachment 3) according to paragraph 9*b*. The examining physician must sign and date the original DD Forms 2351 and 2492.

Also, the medical officer responsible for the examination's accuracy and completeness must sign item 59 on the original DD Form 2351.

b. Within 10 workdays after the examination, the examining facility must send the following to the address in c below:

(1) The original DD Form 2351, properly signed and authenticated (see a above).

(2) Any consultation reports.

(3) Laboratory reports (if any, other than those recorded on DD Form 2351, items 27, 28, and 29).

(4) The DD Form 2492, signed by the examinee and the examining physician.

(5) The SF 520, Clinical Record–Electrocardiographic Record, showing electrocardiographic (ECG) tracings, properly mounted, identified, and interpreted. (Multiple channel ECGs need not be mounted).

(6) DD Form 2480, properly annotated and signed by the examining dentist (attachment 4).

(7) All dental radiographs (bite-wings and panoramic x-rays) properly processed.

(8) All medical documentation the examinee presented.

(9) Diagnostic dental casts, if required by paragraph 9a(4), sent in a separate package, marked with the examinee's name and social security number (SSN).

c. All items required by b above must be sent to the DODMER-B.Assemble and staple all forms and dental radiograph in the order listed. Address material to: DOD Medical Examination Review Board(DODMERB), USAF Academy CO 80840–6518. DO NOT address mail to Commanding Officer, USAF Academy CO 80840–6518. This result in medical correspondence being routed to the Superintendent's office at the Air Force Academy, where it will be delayed in reaching the DODMERB.

d. The examining facility must keep one complete copy (carbon or duplicate) of each item in b above, except b(8), then dispose of these items according to parent service record disposition standards; e.g., AFR 12–50, volume II.

e. Some helpful hints:

(1) Do:

(a) Mail as many examination reports in one package as possible.

(b) Send packages weighing 12 ounces or less as First-Class Mail.

(c) Send packages weighing over 12 ounces as "Priority" mail.

(d) Staple all papers and x-rays in the upper left corner.

(e) Review all items for legibility and positive identification of the examinee.

(2) Do Not:

(a) Send a letter o transmittal.

(b) Complete or send any Privacy Act Statement (DD Form 2005, Privacy Act Statement–Health Care Records).

(c) Send medical examination reports or remedial medical information via Certified or Registered mail.

6. Hospitalization of an Applicant.

When hospitalization is required as part of the medical examination, the applicant may be admitted to a DOD MTF under the authority of appropriate service regulations; e.g., AFR 168–6, AR 40–3, NAVMEDCOMINST 6320.3, Uniform Military Training and Service Act (62 Stat 604.50 U.S.C., App 451).

7. Civilian Consultation and Additional Evaluations.

When supplemental reports, such as specialty consultations and laboratory procedures, are essential to evaluate an examinee properly, the examining facility should do them whenever possible.

a. If these services are not available, the facility may purchase these services from civilian sources, at government expense, providing funds are available. If funds are not available, or these services cannot be offered because of scheduling, distance, or the like, the examinee must be given the opportunity to travel at his or her own expense to a government facility that can provide these services. In that case, tell the examinee to call the other government facility for an appointment in advance. The examinee may also get these services, at his or her own expense, from a civilian source, and have

results sent directly to the address in paragraph 5*c*. Applicant should be provided SF 513, Medical Record–Consultation Sheet, which provides pertinent history and specifically delineates the specialty information needed and authorized lab tests required. Invasive or potentially dangerous procedures are not authorized. Communicate with DODMERB in questionable cases.

b. Results of the medical examination should be sent without waiting for supplementary evaluations or their results. Any instructions given to the examinee will be explained on DD Form 2351. Results of additional tests or evaluations should be sent separately, when they become available.

8. Direct Communications.

The Director, DODMERB, is authorized to communicate directly with the commanders of each designated examining facility about medical examinations, procedures, techniques, deficiencies, and general supervision of medical examination processing. The Director, DODMERB, may send a copy of any correspondence with the examining facilities to the office of primary responsibility of the appropriate Surgeon General office.

9. Scope of Examination:

a. Dental Examination:

(1) General Information. The dental officer thoroughly examines the mouth, teeth, and supporting structures of the examinee and records of his or her findings in blue–black or black ink on the DD Form 2480(attachment 4). While the examining dental officer must inform the candidate of existing deficiencies, pathology, or abnormalities, the examiner is not authorized to advise the examiner whether or not he or she is within dental standards. Therefore, the dental examiner should not point out the specific treatment that might be needed to meet the standards. If such instructions are necessary, the DODMERB must give these instructions to the examinee after evaluating all results of the dental examination. Generally, all dental expenses will be borne by the examinee. Dental radiographs and study casts are authorized to be obtained from the Department of the Army, Navy and Air Force dental facilities at no expense to the examinee.

(2) *Dental Radiographs.* All examinees receive the Type 2 Dental Examination. This includes both mirror and explorer examination under adequate illumination. Bite–wing radiographs on bite–wing film and a panoramic radiograph are required. When an examinee is wearing a fixed, active orthodontic appliance, excluding retainers on both arches, only a panoramic radiograph is required. Bite–wing x–rays are not needed in these cases. A full mouth x–ray survey should not be performed in place of a panoramic x–ray.

(a) If the examination facility does not have a panoramic x-ray, offer the examinee the opportunity to go to another government facility, traveling at his or her own expense. In such cases, advise the examinee to call for an appointment. As an alternative, the examinee may obtain the panoramic x-ray (and not a full-mouth survey) from a civilian dentist at his or her own expense.

(b) The examining dental officer may obtain additional radiographs (for example, periapical or occlusal views) if it is necessary to demonstrate pathology or other abnormalities.

(c) Identify all radiographs with the examinee's full name and SSN. Process thoroughly, and wash and dry radiographs before sending them to the DODMERB. All x-rays must be of diagnostic quality.

(3) *Charting Dental Defects.* All dental defects of the examinee are shown on DD Form 2480. Indicate on the chart (DD Form 2480, item 3) all teeth that are restorable or nonrestorable, missing teeth, teeth replaced, spaces closed, location of cavities, and any defects or abnormalities of the teeth and surrounding structures. Don not chart existing restorations unless they are defective.

(4) *Diagnostic Dental Casts*. In cases of questionable occlusion, disfiguring spaces between anterior teeth, malformation of the jaw, or malrelation of the jaw, dental casts must be made of maxillary and mandibular dental arches. Leave any existing prosthetic appliances in place when you make impressions. Draw pencil lines

across facial surfaces of both casts to show the habitual occlusal relationship. Identify each cast clearly with the examinee's name and SSN, and send both casts to the DODMERB. Indicate on DD Form 2480, item 101, that you are sending casts.

(5) *Malocclusion*. Any questionable occlusion or definite malocclusion related to an insufficient incisal or masticatory function, the malformation or malrelation of jaws or opposing teeth, or a facial deformity must be noted on the DD Form 2480, item 10. Any additional remarks about the type, degree, or severity of the malocclusion should be added in item 16 (attachment 4).

(6) *Orthodontics*. If the examinee wears a fixed, active orthodontic appliance, or is undergoing orthodontic treatment that includes an active removable appliance, or is wearing retainer appliances, or has a past history of orthodontic treatment, please note that fact on the DD Form 2480, item 11.

(7) *Periodontal Conditions*. If significant periodontal disease is present (not simple gingivitis), the location, nature, and severity of the problem must be described on the DD Form 2480, item 13.

(8) *Dental Prostheses.* The dental examination must include an opinion about the serviceability of all dental prostheses. A serviceable prosthesis must adequately restore masticatory function and appearance, and permit clear speech. Oral tissues supporting the prosthesis must be healthy. Any comments must be recorded on the DD Form 2480, item 12.

(9) Cleft Palate or Cleft Lip. If the examinee as a history of cleft palate or cleft lip, whether repaired or not, your comments must be recorded on the DD Form 2480, items 9d and e, to include existing fistulae or other defects.

b. Medical Examinations:

(1) DD Form 2492, DODMERB Report of Medical History:

(a) The examinee's complete medical history must be recorded on the DD Form 2492.

(*b*) The examinee completes the first two lines, all of Section I and II (items 1 through 94), and the Remarks (if necessary) of the DD Form 2492 in his or her own handwriting, using blue–black or black ink or indelible pencil.

(c) The examinee's identification is self-explanatory, but you may help the examinee fill out these in the standard format.

(d) The examinee completes items 1 through 94 and Remarks (the examinee should mark "Not Applicable" or "N/A" in item 9, if appropriate). If item 21 "wear contact lenses or ocular eye retainers, " is marked "yes," explain type of lenses or retainers and length of time removed before examination (see attachment 3). As the examinee may give vague or imprecise information in the 'Remarks' section, all answers must be carefully reviewed, and the examinee asked to clarify answers, whenever necessary (note that answers in items 1 through 10 do not need remarks). The examiner must elaborate on medical history items that are not adequately explained by examinee.

(e) Some general guides for completing examiner's summary and elaboration of pertinent data:

I. Do not use the term "usual childhood illnesses." You may group childhood illnesses together, listing each one.

2. Record the date or age of incident.

3. Do not use "NS" or "nonsymptomatic" in the history. You may use "NCNS," "no comp, no seq," or "no complications, no sequelae" after items of history.

4. Elaborate on all items of history answered "Yes" that are not adequately explained by examinee. Number your amplifying responses to correspond to the affirmative responses of DD Form 2492.

(2) *DD Form 2351*. Attachment 2 gives an item–by–item explanation of DD Form 2351, with model entries. Complete all items, as specified.

10. Supply of Forms:

a. DD Forms 2351, 2480,a nd 2492 are part of the scheduling package DODMERB sends to lists of applicants provided by the academies, ROTC programs and the USUHS.

b. Local reproduction of blank DD Forms 2351, 2480, 2492 is authorized by the Army, Navy, Coast Guard, and Air Force through

the applicable forms manager and reproduction facility. Print DD Form 2480 and 2492 head-to-foot. Print DD Form 2351 face only.

c. The DD Forms listed below are provided to the applicant by DODMERB when remedial medical tests are required; however, a small stock of these forms will be maintained by each medical facility in the event applicants arrive at the medical facility without the appropriate forms to record remedial test results. Local reproduction is authorized based on the specific requirements of the particular agency.

(1) DD Form 2369, DOD Medical Examination Review Board(DODMERB) Cycloplegic Refraction (attachment 5).

(2) DD Form 2370, DOD Medical Examination Review Board(DODMERB) Three-day Blood Pressure and Pulse Check (at-tachment 6).

(3) DD Form 2371, DOD Medical Examination Review Board(DODMERB) Update of Applicant's Medical Examination (attachment 7).

(4) DD Form 2372, DOD Medical Examination Review Board(DODMERB) Statement of Present Health (attachment 8).

(5) DD Form 2374, DOD Medical Examination Review Board(DODMERB) Heart Murmur Evaluation (attachment 9).

(6) DD Form 2375, DOD Medical Examination Review Board(DODMERB) Pulmonary Function Studies (attachment 10).

(7) DD Form 2377, DOD Medical Examination Review Board(DODMERB) Red/Green Color Vision Test (attachment 11).

(8) DD Form 2378, DOD Medical Examination Review Board(DODMERB) Statement of History Regarding Headaches (at-tachment 12).

(9) DD Form 2379, DOD Medical Examination Review Board(DODMERB) Statement of History Regarding Head Injury (attachment 13).

(10) DD Form 2380, DOD Medical Examination Review Board(DODMERB) Statement of History Regarding Sleepwalking (attachment 14).

(11) DD Form 2381, DOD Medical Examination Review Board(DODMERB) Statement of History Regarding Motion Sickness (attachment 15).

(12) DD Form 2382, DOD Medical Examination Review Board(DODMERB) Statement of History Regarding Hay Fever, Sinusitis, Asthma and/or Allergies (attachment 16).

(13) DD Form 2383, DOD Medical Examination Review Board(DODMERB) Statement of History Regarding Medication (attachment 17).

(14) DD Form 2389, DOD Medical Examination Review Board(DODMERB) Farnswork Lantern Color Vision Test (attachment 18). When locally reproduced, printed head-to-foot.

d. DD Form 2368, DOD Medical Examination Review Board(DODMERB) Service Academy ROTC Medical Qualification Determination;2373, DOD Medical Examination Review Board (DODMERB) Notification of Failure to Appear for Service Academy ROTC Medical Examination; and 2503, DOD Medical Examination Review Board (DODMERB) Applicant Overseas Appointment, are stocked and used only by DODMERB.

e. Attachment 19 provides guidelines for conducting certain medical tests; e.g., Reading Aloud Test (RAT), sitting height, Red Lens Test, etc.

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Figure 2-1. DD FORM 2351, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL EXAMINATION

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Figure 2-2. DD FORM 2351, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL EXAMINATION

ITEM-BY-ITEM EXPLANATION FOR FILLING OUT DD FORM 2351

Explanation	Model Entry
Item 1—Date of Examination. Record dates in military style.	14 January 1985 21 Mar 85
Item 2—Last Name, First Name, Middle Name. Record the Entire middle name.	Jones, Harry William, Jr. Martinez, Catherine, Lucinda
Item 3—Social Security Number.	111–22–3333 001–01–1001
Item 4a—Date of Birth. Record date in military style.	15 Feb 68 29 Apr 67
Item 4b—Age.	17 18
Item 5—Sex. Do not abbreviate	Male Female
Item 6—Race (Ethnic Group). Do not abbreviate. Do not confuse with religion.	Caucasian, Black, Oriental, Indian (American), Puerto Rican, Mexican–American
Item 7—Home Address. Enter the address and nine–digit ZIP Code where the examinee receives mail.	1234 Main St. Colorado Springs CO 80840–6518
Item 8—Military Status. Check the block designating the applicant's current status.	
Item 9—Examiner Address. Complete name and address of agency doing examination	USAF School of Aerospace Medicine Brooks AFB TX 7823–5000
Item 10—Height. Record standing height in inches, without shoes, to the nearest quarter of an inch. Also measure every applicant's sitting height to the nearest quarter of an inch, and record it.	Standing 61 1/4 Sitting 36 3/4
Item 11—Blood Pressure.Record the sitting blood pressure.	120/84
Item 12—Electrocardiogram (EKG). Give every examinee a 12–lead EKG. The examinee does not have to be fasting. Check normal or abnormal, and submit actual tracings.	
Item 13—Audiometer. Give an audiometer test, include fire- quencies 500, 1000, 2000, 3000, 4000, and 6000 Hertz (Hz). Indicate the type of standards (American National Standards Institute (ANSI) American Standards Association (ASA, 1951, or International Standard Organization(ISO), 1964.	
Item 14—Reading Aloud Test (RAT). Give the RAT (attachment 19) and mark it as "satisfactory" or "unsatisfactory." If RAT is unsatisfactory, summarize the defects that caused failure in item 57.	
Item 15-Pulse. Record the resting pulse in beats per minute.	72
Item 16-Weight. Measure weight in pounds, the nearest	150

Figure 2-1. ITEM-BY-ITEM EXPLANATION FOR FILLING OUT DD FORM 2351-Continued

whole pound, with the examinee wearing no more than underwear.

Item 17 through 26. Before conducting vision test, find out is the examinee is wearing contact lenses. Soft contact lenses must be removed a minimum of 3 days before the examination. All other types of contact lenses (hard, semisoft, retainers, color– correcting, etc.) must be removed 21 days before the examination. If contact lenses have not been out the required period of time, note the fact in item 57 and continue with the examination. Have the examinee remove them for those tests where lenses would obviously cause erroneous results, such as items 17 and 19 (uncorrected vision). If the examinee usually wears corrective lenses (spectacles or contacts), have the examinee wear them during depth perception and color vision testing; however, make sure that lenses are not "color corrective."

Item 17—Distant Vision.Record distant visual acuity with a constant numerator of 20 (20 feet), and a denominator that depends on the individual's vision. If acuity is worse than right eye or left eye, than record the correctable visual acuity. If the examinee is not able to read all of the letters on the 20/20 line, than record the number of missed letter; e.g., 20/20–1; 20/30–2; 20/20–3, etc., or record the next higher line; e.g., 20/20–3 – 20/25. Measure visual acuity with Vision Test Apparatus–Near and Distant(VTA–ND), or in the eye lane. When using the VTA–ND and the examinee does not success–fully complete the top line of the 20/400 line, then record 20/400+ or refer examinee to the optometrist to determine the proper visual acuity.

Item 18—Refraction. OTHER THAN US AIR FORCE ACADEMY. Complete this item on every examination where Distant or near visual acuity is worse than 20/20, right eye or left eye. Enter the prescription that corrects acuity to 20/20, and after the word "Refraction" mark how you derived that prescription; "manifest," "cycloplegic," or "lens" if the prescription is read from spectacles.

US AIR FORCE ACADEMY. Every applicant for the US Air Force Academy whose uncorrected distance visual acuity is 20/20 or better in both the right and left eyes must have a cycloplegic refraction. Enter the prescription that corrects acuity to no better than 20/20 and after the word "Refraction" check "CYCLO."

Item 19—Near Vision. Record results in terms of reduced Snellen. Whenever the uncorrected vision is worse than normal (20/20), show the corrected vision for each eye, and lens value after the word "by."

Item 20—Heterophoria. In routine testing for heterophoria, Check only "Far" on the VTA–ND, or "20" in the eye lane. Do not enter the symbol for diopters; the unit of measurement is understood. Enter the amount of exophoria or esophoria and right or left hyperphoria.

Item 21—Cover Test. Test muscle balance deviation (phorias or tropias) by use of the objective Cover Test (CT). If you find esotropia or exotropia on the CT (cross or alternate cover and cover–uncover) check "fail" and record the amount in the bottom of the box. If the examinee is orthophoria, check

20/50 corrected to 20/20 20/20-3 corrected to 20/20 20/400+ 20/20,

Refraction (manifest By SPH - 1.50 CYL + .50 AXIS 090

20/40 corrected to 20/20 by same. 20/40 corrected to 20/20 by +0.50

Figure 2-1. ITEM-BY-ITEM EXPLANATION FOR FILLING OUT DD FORM 2351-Continued

Item 22—Color Vision. Test examinees with the standard 15–plate Vision Test Set, Color Vision (VTS–CV). Check the test(s) used and enter both the number passed and the number failed. If the Farnsworth Lantern (FALANT) is available, use it for those who fail the plate test. Also, use it if you suspect the examinee has memorized the plates. Enter FALANT results to the right of the word "FALANT." Be sure to specify the name of other tests and the numerical result. If the examinee fails the FALANT or 15–plate Vision Test Set, check for the ability to distinguish and identify, without confusion, those colors of objects, substances, materials, or lights that are vivid red and vivid green; record results in item 57.

Item 23—Dept Perception. Test the examinee with correction, if any. For VTA–ND if the examinee passes, enter "passes" and give the highest level passed (D, E, or F) in parentheses. For Verhoeff (DPA–V), enter "passes" or "fails" and the number correct over number presented. For Titmus/Stereo Fly, circle the actual test used and enter the numerical result.

Item 24—PC (Near Point of Convergence). Measure the near point of convergency (NPC) in millimeters (mm).

Item 25—Accommodation.Have the examinee take this test with corrective lenses if worn.

Item 26—Red Lens Test.Note the point on the screen where diplopia or suppression develops. Mark "pass" if the examinee has no diplopia or suppression within 20 inches of the primary position. position in the center of screen, with the examinee seated 30 inches from the screen. Describe any abnormalities accurately in item 57.

Item 27—Urinalysis. Check the appropriate boxes for protein and sugar. Indicate results of microscopic examination; multi– reagent strips may be used if negative. If the multireagent strip is not negative, an actual microscopic examination must be performed and the results annotated.

Item 28a and b—Blood Type and RH Factor. Record results in these blocks.

Item 28c and d—Hematocrit and Hemoglobin. A hematocrit or hemoglobin level is required.

Item 29—Other Tests. For other medical tests as indicated; e.g., HIV (all exams), dental results (POC only), blood alcohol testing (BAT) and urine drug screen (UDS).

Item 30 through 56—Clinical Evaluation. Make a check in the proper column. When there are clinical findings to record or comment on, check the proper column (normal or abnormal) and enter pertinent information in the space provided to the right, beginning with the item number. (See instructions on DD Form 2351).

Item 30—Head, Neck, Face, and Scalp. Record all swollen glands, deformities, or imperfections of the head and face. If enlarged lymph nodes of the neck are detached, describe them

a. VTA–ND passes (F)b. DPA–V passes (8/8)c. Titmus/Stereo Fly 70

35mm

Right 10.0, Left 9.5

Diplopia in left lateral gaze, 10 inches, from primary

Type A Rh factor–Pos

2 RBC

3 WBC

Hematocrit 44 Hemoglobin 16.5

HIV–Negative Dental Class 2 BAT–Negative UDS–Collected

a. 2cm vertical scar right forehead, well healed, no sequelae (WHNS).

Figure 2-1. ITEM-BY-ITEM EXPLANATION FOR FILLING OUT DD FORM 2351—Continued

In detail and give a clinical opinion of the etiology.

Item 31—Nose. Record all abnormal finding. If septum is deviated, estimate the degree of obstruction and tell whether airflow is adequate.

Item 32-Sinuses. Record objective finding only.

Item 33—Mouth and Throat. Note whether tonsils have been removed. Record any unusual findings.

Item 34—Ears–General (Including External Canals). If operative scars are noted over the mastoid area, include a notation of simple or radical mastoidectomy in item 57.

Item 35—Drums (Perforation). Record the location and size of any perforation. If there is scarring of the tympanic membrane, record the percent of the membrane involved, and evaluate the mobility of the membrane.

Item 36—Valsalva. Indicate whether or not both eardrums move on Valsalva Maneuver (mark normal only if both drums move).

Item 37—Eyes–General. When there is ptosis of lids, make a statement about the cause and whether it interferes with vision. When you detect a pterygium, note the following: (a) Encroachment on the cornea.

(b) Progression.

(c) Vascularity. Check particularly for radial keratotomy or evidence of othokeratology or other procedures employed to improve visual acuity.

Item 38—Pupils (Equality and Reaction).

Item 39—Ocular Motility (Associated Parallel Movements, Nystagmus).

Item 40—Ophthalmoscopic.If you detect opacities of the lens, make a statement about size, type, progression, and interference with vision.

Item 41—Lungs and Chest (Include Breasts). Record all abnormal findings. Note whether there are any abnormalities of the rib cage, muscles, chest excursion, palpation, percussion, and auscultation.

Item 42—Heart (Thrust, Size, Rhythm, Sounds). Describe any abnormal heart findings completely. Whenever you hear a cardiac murmur, describe the time in the cardiac cycle, and the intensity, location, transmission, and effect of respiration or change in position; and state whether you think that the murmur is organic or functional. When describing murmurs by b. 2 discrete, freely movable, firm, 2cm nodes in right anterior cervical chain, probably benign. Has upper respiratory infection.

a. Moderate obstruction on right, due to septal deviation, airflow adequate,

asymptomatic.b. Mouth breathing noted.c. Large nasal polyps present in both chambers.

Marked tenderness over left maxillary sinus. Poor transillumination.

Tonsils enucleated.

Bilateral sever swelling, injunction, and tenderness of ear canals.

Small perforation, right upper quadrant of left tympanum.

No motion on valsalva, right ear.

a. Ptosis, bilateral, congenital. Does not interfere with vision.b. Pterygium, left eye. Does not encroach On cornea, nonprogressive avascular.

Redistribution of pigment, macula, right eye, possibly due to solar burn. No evidence of active organic disease.

Sibilant and sonorus rales throughout chest. Prolonged expiration.

a. Grade II/IV soft, systolic murmur heard only in pulmonic area and on recumbency, not transmitted, disappears on exercise and deep inspiration (physiologic

b. Late soft systolic "click" heard over

Figure 2-1. ITEM-BY-ITEM EXPLANATION FOR FILLING OUT DD FORM 2351—Continued

murmur)

grade, indicate basis of grade (IV or VI). Note any additional sounds (clicks, etc.) and their time in the cardiac cycle, synchrony, and intensity; and whether you think they are of cardiac origin or adventitious.

Item 43—Vascular System (Varicosities, etc.). Describe any abnormalities adequately. When varicose veins are present, give their location, severity, and evidence of venous insufficiency. Check for the presence or absence of carotid, radial, femoral, popliteal, and pedal pulses. Specifically, record any absent pulses or presence of a bruit over any artery.

Item 44—Abdomen and Viscera (Include Hernia). Note any abdominal scars and describe the length in centimeters, their location and direction. If you find a dilated inguinal ring, state whether a hernia is present or absent.

Item 45—Endocrine System. Specifically record asymmetry, enlargement, or the presence of nodules in the thyroid gland.

Item 46—Spine, Other Musculoskeletal (Including Pelvis, Saroiliac, and Lumbosacral Joints). If you detect scoliosis or Other musculoskeletal defects, either by examination or as an incidental chest x-ray finding, describe any defects as accurately as possible.

Item 47—Upper Extremities. Record any deformity or limitation of motion. If the applicant has a history of previous Injuries or fracture of an upper extremity(for example, a history of a broken arm with no significant finding at time of examination), indicate that there is no deformity and function is normal. Make a positive statement, even though you check the "Normal" column.

Item 48-Lower Extremities. Report as in item 47

Item 49—Feet. Note any abnormality. When you detect flat Feet, make a statement about the stability and the presence or absence of symptoms. Do not express pes planus in degrees; record it as mild, moderate, or severe. Indicate if orthotic devices or special footwear are used.

Item 50—Identifying Body Marks, Scars, or Tattoos. Record only scars or marks useful for identification.

Item 51—Skin, Lymphatic. Describe pilonidal cyst or sinus, and tell whether symptomatic in past or at present. If there is a skin disease, tell what it is, record its chronicity, severity, and Response to treatment in item 57. If you detect a skin disease of the face, back, or shoulders, state whether the defect will interfere with wearing an oxygen mask or whether wearing a parachute harness, shoulder straps, or other military equipment will irritate it.

Item 52—GU (Genitourinary) System. If you detect a varicocele or hydrocele, indicate the size in relation to the opposite testicle and whether it is symptomatic. If you detect an undescended testicle, describe its location, particularly in

the second left intercostal space, parasternally, not varying in intensity with respiration, probably of cardiac origin.

Varicose veins, mild posterior superficial veins of legs. No evidence of venous insufficiency. Asymptomatic.

2.5cm linear diagonal scar right lower quadrant, well healed, no sequelae (WHNS).

Left lobe diffusely enlarged; 2cm hard, nontender nodule near isthmus.

Scoliosis, thoracic spine, minimal deviation to right.

No weakness, deformity or limitation motion, left arm.

Flat feet, moderate, stable, asymptomatic.

a. 1cm vertical linear scar, dorsum left forearm, WHNS.b. 3cm heart–shaped tattoo, lateral aspect, middle 1/3 left forearm.

a. Acne vulgaris, mild, face, will not interfere with wearing oxygen mask or combat equipment.
b. 5×5cm burn scar, left pretibial region. May be subject to trauma by combat boots, or breakdown by water immersion.

Varicocele, left, small, asymptomatic

Figure 2-1. ITEM-BY-ITEM EXPLANATION FOR FILLING OUT DD FORM 2351—Continued

relation to the inguinal canal.

Item 53—Anus and Rectum. Check for hemorrhoids, and note size, number, and symptomatology. Check for fistula, cysts, etc. At least a visual examination is required on all examinees.

Item 54—Pelvic Examination. Perform a pelvic examination only if medically indicated. If the examination is not performed, enter "NE" in the Normal column. This examination is required for all female examinees 22 years of age and over.

Item 55—Neurologic. Record complete description of any abnormality.

Item 56—Psychiatric. Interview each applicant to evaluate level of maturity, and ability to withstand the rigorous physical and mental stresses of military service. Explain any negative recommendations in detail.

Item 57—Notes. Use this space to describe conditions found during the Clinical Evaluation (item 30 through 56). This space should be used for any other comments relating to items 10 through 29. Be sure to enter the item number before each comment. Use the back of the form, if necessary.

Item 58a—Typed or Printed Name of Examiner. The examiner identified must sign the original. Use block for Physician Assistant (PA) or Primary Care Nurse Practitioners (PCNP) who perform clinical aspect of examination.

Item 58b—Signature of Examiner.

Item 58c—Rank.

Item 58d—Corps or Degree.

Item 59a-Typed or Printed Name of Physician.

- Item 59b-Rank.
- Item 59c—Degree.

Figure 2-1. ITEM-BY-ITEM EXPLANATION FOR FILLING OUT DD FORM 2351

One small external hemorrhoid, asymptomatic

DOD MEDICAL EXAMINATION RE (This information is for official and medic (This form is sub	VIE ally c	WE onfi	BOARD (DODMERI dential use only and will e Privacy Act of 1974 - Se	B) R nut b ee DD	EPC ere	OR1	F OF MEDICAL sed to unauthorized	HIS perso	IOR ns)	Y	OMB	1 Approved 1 No. 0704-0269 res Sep 30, 1989		<u></u>	
NAME (Last, First, Middle Initial) MORAY, HARRY G.			<u> </u>			so	CIAL SECURITY	YNU				ONE NO. (Include) 962-0001	area code))	
PURPOSE OF EXAMINATION DODMERB	TIO 1 i i	N F	ACILITY OR EXAM Hanscom, H	line lan	R A		n F1d MA 0	<i>clude 2</i>)110	ip Ca 1	ode)		DATE OF EXA 5 May 87	MINATI	ON	
SECTION I - Mark applicable boxes in ite	ms 1	l th	rough 10										_		
1. How would you rate your present healt	th?	_			T	6.	If you smoke o	igare	ette	s how many d	o you	smoke each day?			
X Excellent Very Good Good	Γ	F.	air Poor	r		X	Less than 1 pack	۱p	аск	1-1/2 pac	кs	2 packs or more			
2. How many hours sleep do you usually g	jet a	atn	ight?		Т	7.						k do you drink an	y alcoh	olic	
4 or less 5 6 7 X 8	T	9	or more				beverages suc			-	1013				
3. How many days per week do you exerce (enough to produce a sweat) for at least fiftee	ise n mi	vig	orously		- 1-	X	Never (skip to Item 9)	, on		twice		Three or four	mo	_	
	1	T			-	8.	When you drift		w i	many alcoholi	c drink	(s do you have (on	1 1	ige)? ir mo	
None 1 2 3 X 4		5	6 7	_	-		<u> </u>	X ²		<u> </u>		N/A	60	r mo	re
4. Are you on any special diet?					-+	<u>у.</u> Т	Have you ever			·	wing?				
Yes X No					-	+	Amphetamines Cocaine			rates	ł	Chemical inhalants			
5. Indicate the tobacco products you curre	ntly	T			╋	10		-		nogens		Narcotic drugs			
X Cigarettes Cigars Snuff (Smokeless tobacco) Pipes		┢	Chewing tobacco None (Skip to Item 7)		_		What is your n	·	arried	T T	-d	Divorced	1	dowe	ed
		<u> </u>						_							-
SECTION II – Mark each item (11 through "Yes" must be explained in "	94) the	REN	es or No." If you MARKS section on t	u do he r	no eve	τ ki erse	now the answe	r tor	a pa	articular item,	ieave	it blank. Every ite	em mari	ked	
· · · · · · · · · · · · · · · · · · ·	—	1 —	·····						<u>.</u>					τ.	<u>.</u>
A. Does your family have a history of	Yes	No V	• • • • • • • • • • • • • • • • • • •					Yes	No			ver had or do you now	nave	Yes	No X
11 Diabetes or sugar diabetes	+	X	35. Eye trouble (exclu	ide gl	asse	s, cc	ontact		v	64. Back pain or				+	<u>x</u>
12. Heart trouble or strokes	+-	X	lenses)					_		65. Paralysis, far 66. Foot trouble				$\frac{1}{x}$	
13. High blood pressure	+	X	36. Vision change or d	ouble		ion.		_	<u>↓⊼</u>					<u>↓×</u>	-
14. Cancer	+	X	37. Hearing loss							67 Rheumatic f				+	X
15 Mental condition	₊	X	38. Ear, nose, or throa						X	68. Tuberculosis		ive 18 test			X
16 Alcoholism or suicide	+	X	39. Sinusitis or sinus tr						<u>X</u>	69 Homosexual				╉	X
17 Seizures or epilepsy	-	$\frac{1}{3}$						+	X	70. VD, syphilis,	gonorrh	iea, herpes, etc.		+	X
18 Allergies or Asthma		X	•	im tro	bubl	e		<u> </u>	+			as ache, psoriasis,			L.
19 Arthritis or rheumatism	5398	X							$\frac{1}{3}$	nang or too	rasnes,	eczema, or dry skin		–	Х
B. Do you or did you ever			43 Chronic cough or l		isea	se			X	72. Adverse rea					
20 Wear glasses	+	X	44. Asthma or wheezi	<u> </u>				_		ļ		ites or stings		+	X
21 Wear contact lenses or ocular eye		1	45. Unusuai shortness			۱ 			X	73. A weight pr				┢	X
retainers	X	+	46. Pain or pressure in					-+-	X	74. Recent gain				╂	X
22 Have any altergies	X	+	47. Palpitation or pou		_				X	75. Excessive bl				╋	X
23 Fake any medications regularly	╀	X	48. Heart trouble or h 49. High blood pressu		nuri	mur			$\frac{1}{2}$					┢	X
24 Stutter or stammer	+-	X						·		77. Considered				┢	X
25 Wear a bone or joint brace or			50. Coughed up or vor					+	X	78. Sleepwalkin		es		╄	X
support		X							X	79. Easy fatigat			<u> </u>	+	X
C. Have you ever had or do you now have	.		52. Galibladder troubl	·			es		X	80. Car, train, se				X	Ļ.
26 Frequent, severe, or migraine		.,	53. Yellow jaundice or						X	81 X-ray or oth				+	X
headaches	+	X	54. Hemorrhoids or re		iisea	se			X			als, dust,			
27 Fainting or dizzy spells	+	X	55. Black or bloody sto				· · · · · · · · · · · · · · · · · · ·		$\frac{1}{2}$	sunlight, etc				+	<u>₩</u>
28 Periods of unconsciousness	X	+	56 Frequent or painfu			JN		+	X	L		or speech problems		-	Х
29 Head injury or skull fracture	X	l.,	57 Bed wetting since		_				X		IS ONLY	- Have you ever N/	ł	, pilling and a start and a start a st	P
30. Epilepsy, seizures, or convulsions	+	$\frac{1}{2}$	58. Blood, protein, or	sugar	10	ILIU	e		X						
31 Loss of memory or amnesia	+	<u> x</u>	ŧ						X	· · · · · · · · · · · · · · · · · · ·				+	╄
32 Depression, excessive worry or nervousness; anxiety		x	61. Any bone or joint	trouh	ie, t	ours			X	85 Had a chang 86 Been pregn		e you now pregnant		┢	┢
33. Any mental condition or illness	\dagger	$\frac{\Lambda}{X}$		-					$\hat{\mathbf{x}}$			pills (If yes, give		†-	\mathbf{t}
34 Frequent trouble sleeping		X	63. Steel pins, plates.	or sta	ples	un :	any bones		X	dates and p				L	
E. Have you ever				Yes	No	£.	(Contd.) Have yo	u ever	_					Yes	NO
 Been refused employment or been unable to hold a or stay in school because of: 	100				x	91				r have you applied existing disability				Γ	x
a. Inability to perform certain movements?			·····		x	92	Had or have you	ever b	een a	dvised to have, an	iy surgica			t	T
b. Inability to assume certain positions?					X		operations?				-				x
c. Other medical reasons?					X	93	Consulted or beer	n treat	ed by	clinics, hospitals,	physiciar	ns,		\uparrow	1
89 Been rejected for or discharged from military servic because of physical, mental or other reasons?	e				x	-	healers, or other j	practit	ioner	rs for other than m	inor iline	esses?		+	x
90 Been denied or rated up for life insurance?					A X	94	Had any illness or	injury	othe	r than those airea	dy noted	i?			x
DD Form 2492, MAR 87										DoD Exceptio	on to Sl	F93 approved by (SA/IRN	AS 2	-87

Figure 3-1. DD FORM 2492, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL HISTORY-MALE

	xplained in the space below. Give dates and complete details including names of doct	tors and hospitals or clini	is and the current
status of the condition. Continue on a separate sheet and attach to the			
<pre>#21 Wears hard contact lenses. #22 Allergiesgrass, hay and</pre>			
	aust. aying football - knocked out. Seen in		
Luke General Hospit	al, Lloyd NY, September 1982, Dr Jones	emergency	room at
#41 Treated for gingivitis in	1983. No problem since. Dr Fix, Main	Street As	nen CO
#66 Flatfeet. Treated with or	thotics when participating in sports.	Seen by Dr	Jones.
Force MA - 1984.			·····,
#80 Car sickness in childhood.	I've outgrown it. No treatment.		
I certify that I have reviewed the foregoing information of the second	on supplied by me and that it is true and complete to the best of	f my knowledge. T	authorize any
of the doctors, hospitals, or clinics mentioned above to my application for this employment or service.	o furnish the Government a complete transcript of my medical r	ecord for purposes	s of processing
TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE		D
			1
HARRY G. MORAY	Farry D. Moray	10 0	ec 88
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE	D MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNE	L ONLY"	
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE EXAMINER'S SUMMARY AND ELABORATION OF AL	D MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNE LL PERTINENT DATA (Examiner shall comment on all "Yes" and blank answe	L ONLY"	umber befare each
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NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed form) #21 Wear hard contact lenses.	D MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNE LL PERTINENT DATA (Examiner shall comment on all "Yes" and blank answe d important, and record significant findings here. If additional space is needed, cont Lenses removed 22 days prior to exam.	LONLY" rs (indicating the item nu tinue on a separate sheet	umber befare each t and attach to this
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Figure 3-2. DD FORM 2492 Reverse, MAR 87

	ME (Last, First, Middle Initial) ORAY LISA A.					1	soc	ed to unauthorized per $\frac{1}{205}$ CIAL SECURITY I 1 - 11 - 0001			ER			NO. (Include a	rea code)	
UR	POSE OF EXAMINATION EXAMINA			ACILITY OR E C HANSCOM		R A	ND	ADDRESS (Inclu		1 0 1		(10	D	ATE OF EXAM May 87	AINATI	ON
EC	TION I - Mark applicable boxes in ite	ms	1 th	ough 10												
. 1	How would you rate your present heal	th?	_			_	-	If you smoke cig	are	ette	s how man	y do yo	u smok	e each day?		
_	Excellent Very Good Good		-	air	Poor		-	Less than 1 pack	-	ack		packs		acks or more		
-	How many hours sleep do you usually	jet	1	· · · · · · · · · · · · · · · · · · ·		-1		On the average, beverages such					ek do y	/ou drink any	alcoho	olic
_	4 or less 5 6 7 X 8			or more		-		Never (skip to item 9)		s tha			The	ee or	Fixe	or
. (How many days per week do you exerc (enough to produce a sweat) for at least fiftee	n m	inul	es		h		(skip to item 9) When you drink	÷			olic drir	ks do s			
1.	Vione 1 2 3 X 4	T	15	6	7	-†	T	1	12		3		4	5		mo
. /	Are you on any special diet?		4				9.	Have you ever u	sec	d an	y of the fo	lowing	N/	A	h	-
-	X NO						_	Amphetamines		rbitu		¥		emical inhalants		_
. I	ndicate the tobacco products you curre	ntly	/ us	e			ŀ	Cocaine	Ha	Hucor	logens		Nar	rcotic drugs		
Xŀ	ligarettes Cigars			Chewing tobacc	0	1	10.1	What is your ma	rita	al st	atus?					
_	nuff (Smokeless tobacco) Pipes			None (Skip to It	_	X	_	Never Married	<u> </u>	arried	م الم العب العب	rated		orced		wot
EC	TION II - Mark each item (11 through "Yes" must be explained in :	94) the)"Y	es " or "No." I	If you do	not	t kn	ow the answer f	or	a pa	articular ite	m, leave	e it blai	nk. Every itei	m mark	ed
		-	T-		·				-	,	r					r
	A. Does your family have a history of Diabetes or sugar diabetes	Ye	X					lo you now have	Yes	No	C. (Contd.) 64 Back pai			t or do you now h	ave	Ye -
	<pre>subles of stokes</pre>	╀	$\frac{1}{1}$	 Eye trouble lenses} 	(exclude gi	asses	i, cor	ntact		х	65 Paralys:					-
_	high blood pressure	┢	X	36. Vision chang	e or doubl	e visio	on		+-	X	66 Foot tro					x
_	lancer	+	Îx	37 Hearing loss					\vdash	X	67. Rheuma					Ê
5. N	vental condition	+	$\frac{1}{v}$	38. Ear, nose, or	throat tro	uble	·		┢╌	X	68. Tubercu		itive TB 1	test		F
6. A	Alcaholism or suicide	\top	x	39 Sinusitis or si	nus troubl	e				X	69. Homose	ual activit	y			F
7. S	eizures or epilepsy	1	x	40. Hay fever or	allergic rh	initis				X	70. VD, sypt	ilis, gonor	rhea, her	pes, etc		1
8 4	Allergies of Asthma	Τ	X	41. Severe tooth	or gum tr	ouble	•		Х		71. Skin con	ditions suc	h as acne	, psoriasis,		Γ
9 A	Arthritis or rheumatism	Γ	Х	42. Thyroid trou	ble			•		X				a, or dry skin		İ
8	8. Do you ar did you ever			43. Chronic coug	h or lung o	liseas	se			Х	72. Adverse	reaction to	o serum,	drugs,		
0 1	Near glasses	⊥	X	44. Asthma or w				· · _ · · · · · · · · · · · ·		X		, food, or	bites or s	stings		4_
	Near contact lenses or ocular eye			45. Unusual shor				. <u></u>		X	73. A weigh					L
	etainers	X		46. Pain or press						X	74. Recent o	···-				-
	Have any allergies	X	$\frac{1}{1}$	47. Palpitation C 48. Heart trouble						X	75. Excessiv					
	stutter of stammer	╋	x	49. High blood p		nurir			┝╌	X	76. Tumor, s 77. Conside					┢─
	······································	╀╌	┢	50. Coughed up		blog	xd.		┢─	X	78 Sleepwa			1000		┢
	Wear a bone or joint brace or support			51. Stomach, live				ible		л Х	79 Easy fat					┢
	C Have you ever had or do you now have		Ê	52. Gallbladder					┢╴	X	80. Car, trai		ir sicknes	55		v
6 6	frequent, severe, or migraine	ſ	Ť	53. Yellow jauno	dice or hep	atitis				x	81 X-ray of	other radi	ation the	rapy		Â
	headaches		k	54. Hemorrhoids	s or rectal o	liseas	se		\vdash	X	82. Sensitiv	ty to chem	icais dus	st.		F
27. F	Fainting or dizzy spells		k	55. Black or bloc	dy stools					X	sunlight					
2 8 P	Periods of unconsciousness			56. Frequent or	painful uri	natio	n			Х	83 Learnin	disabilitie	es or spee	ech problems		
9 1	Head injury or skull fracture	12	4	57 Bed wetting					L	X	D. FEN	ALES ON	Y - Have	e you ever		
	Epilepsy, seizures, or convulsions	+	Ļх	58. Blood, prote		r in u	rine	· · · · · · · · · · · · · · · · · · ·	ļ	X	84. Been tre			lisorder.		
	Loss of memory or amnesia	+		59. Kidney stone					┝	X	<u> </u>	eriods, or				┡
	Dépression, excessive worry or nervousness, anxiety		1	60. Hernia or ruj		la h		*iz	┝	X	85 Hadach		a			┢─
	Any mental condition or illness	+	$+\frac{X}{V}$	62 Broken bone	<u> </u>				┼	X	t · · · · · · · · · · · · · · · · · · ·			low pregnant		
	Frequent trouble sleeping	+	\uparrow	63. Steel pins, pl	·			ny bones	┢	X	87. Taken b dates ar	rth contro d product		yes, give	1	
, ,	E. Have you ever							(Contd.) Have you e								Ye
	Been refused employment or been unable to hold a	ioh						Received, is there pe			have you and	lied for		——————————————————————————————————————		
	or stay in school because of:					х	-1.	pension or compensa								
	a Inability to perform certain movements?		_			Х	92.	Had, or have you eve	er ibe	en a	dvised to have	, any surgi	ical			Γ
	b Inability to assume certain positions?					Х		operations?								
	c Other medical reasons?					Х	93.	Consulted or been tr								Γ
	Been rejected for or discharged from military service because of object of montal or other reasons?	2						healers, or other pra	ctiti	oner	s for other tha	n minór ill	nesses7			L
	because of physical, mental or other reasons?					IX I		Had any illness or inj								L L

Figure 3-3. DD FORM 2492, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL history—FEMALE

status of the condition. Continue on a separate sheet and attach to this	plained in the space below. Give dates and complete details including names of doct s form if additional space is needed.)	tors and hospitals or clinics and the curi	rent
#21 Wear soft contact lenses.			
#22 Allergiesgrass, hay and	dust.		
	aying softball - knocked out. Seen in	n emergency room a	t
George General Hos	pital, Rome NY, July 1985, Dr Henry.		
	1982. No problem now. Dr Gabelman, H		
	thotics when participating in sports.	Seen by Dr Willi	.ams,
Salem MA.	• • •		
#80 Car sickness in childhood.	I've outgrown it. No treatment.		
	on supplied by me and that it is true and complete to the best o		
of the doctors, hospitals, or clinics mentioned above to my application for this employment or service.	o furnish the Government a complete transcript of my medical r	record for purposes of proces	ssing
TYPED OR PRINTED NAME OF EXAMINEE	ISIGNATURE	DATE SIGNED	
TTPED OR PRINTED NAME OF EXAMINEE			
LISA A. MORAY	Visa I Maray	16 her of	
	D MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNI	IL here do	
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NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed		EL ONLY"	
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed form.)	L PERTINENT DATA (Examiner shall comment on all "Yes" and blank answer I important, and record significant findings here. If additional space is needed, con	EL ONLY" ers (indicating the item number before tinue on a separate sheet and attach t	
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NOTE: HAND TO DOCTOR OR NURSE OR IF MAILER EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed form.) #21 Wear soft contact lenses. #22 Allergic rhinitis during s #28 and 29 HX of concussion in evaluation, WNL, N #41 Treated for Gingivitis 198 #66 Flatfeet. Wears orthotics	L PERTINENT DATA (Examiner shall comment on all "Yes" and blank answed important, and record significant findings here. If additional space is needed, con Spring, treated with OTC medications, w 1 1986, LOC 2 minutes, skull x-rays neg NCNS. 32, resolved. 5 when participating in sports.	EL ONLY" ers (indicating the item number before tinue on a separate sheet and attach t well controlled, N	to this ICNS .
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DOD MEDICAL EXAMINATION RE (This information is for official and medic (This form is sub	ally c	onfi	dential use d	only and will	not t	oe re	leas	ed to unauthorized p	HIST	OR s)	Y .	fo ON Exj	rm A MB Ni pires	pproved o 0704-0269 Sep 30, 1989		
NAMF (Last, Zirst, Middle Initial)							so	CIAL SECURITY	NUN	ЛB	R	TELE	РНС	DNE NO. (Include ar	ea code)	1
PURPOSE OF EXAMINATION EXAMINA	noi	NF	ACILITY	DR EXAN	AINE	RA	ANC	ADDRESS (Inclu	ude Zı	p Ca	de)			DATE OF EXAN	IINATI	ON
SECTION I - Mark applicable boxes in iter	ns 1	th	rough 10													
1. How would you rate your present healt	h?						6.	If you smoke cig	garet	tte	how m	any do yo	u sn	noke each day?		
Excellent Very Good Good		F	air	Poo	r	Ι	Τ	Less than 1 pack	1 pa	ick	1.	/2 packs		2 packs or more		
2. How many hours sleep do you usually g	et a	-				_	7.	On the average beverages such					ek	do you drink any	alcoho	olic
4 or iess 5 6 7 8	ļ	<u> </u>	or more			-	Т					nce or	r	Three or	Five	201
 How many days per week do you exerce (enough to produce a sweat) for at least fifteer 						ŀ		Never (skip to Item 9)	Less			nce		Three or four	mor	re
None 1 2 3 4	F	5	6	7		╉	T	venen you arink	12	wr	nany aic	DRONC OF	nks T	do you have (on the last of th		ge)f more
4. Are you on any special diet?				_ _		+		Have you ever u	used	an	v of the	ollowing	?			
Yes No						-	Ť	Amphetamines	-		ales		T	Chemical inhalants		
5. Indicate the tobacco products you curre	ntly	us	e.				1	Cocaine	Hall	ucin	ogens		t	Narcotic drugs		
Cigarettes Cigars		Γ	Chewing	tobacco			10.	What is your ma	arital	sta	itus?					
Snuff (Smokeless tobacco) Pipes			None (Sk	ip to Item 7)	1		Ι	Never Married	Mar	rriec	5	parated		Divorced	Wid	lowed
SECTION II - Mark each item (11 through	94)	″γ	es " or "N	lo." If you	u do	no	t kr	ow the answer	for a	ра	rticular	tem, leav	e it	blank. Every iten	n mark	ed
"Yes" must be explained in t	he l	REN	MARKS se	ction on t	he r	eve	erse									
A. Does your family have a history of	۲es	No	C. (Conto	1.) Have you	ever	r had	l or o	lo you now have	Yes	No	C. (Cont	d.) Have you	i eve	r had or do you now ha	ave	Yes No
11 Diabetes or sugar diabetes				ouble (exclu	ide gl	asse	s, co	ntact			64 Back	pain or troub	e			
12 Heart trouble or strokes			lenses)							65. Paral	isis, lamenes	s, or	weakness		
13 High blood pressure	-	L_	<u> </u>	change or d	loubl	e vis	ion		\downarrow		66. Foot					\square
14. Cancer		⊢	37. Hearin	<u> </u>					+			natic fever				
15. Mental condition	+	┢		ose, or throa					╉╍┨	_		culosis or po		TB test		++
16 Alcoholism or suicide 17 Seizures or epilepsy	+-	┝		tis or sinus tr					╁╶╂	_		sexual activi				┢╼┟╴
18. Allergies or Asthma		┝	+ · · · · · · · · · · · · · · · · · · ·	e tooth or gu					+	_	70. VD, S	philis, gonor	rrnea	, herpes, etc.		++-
19. Arthritis or rheumatism	╉	┝	42 Thyro				-		+	-				acne, psoriasis, zema, or dry skin		
B. Do you or did you ever				ic cough or I	una	lisea	S.P.		┼┤							┟─┼╌
20 Wear glasses				a or wheezi	-				+			se reaction t ine, food, or				
······································		┢	· · · · · · · · · · · · · · · · · · ·	al shortness		reath	 h					ght problem				
21 Wear contact lenses or ocular eye retainers			· · · · · · · · · · · · · · · · · · ·	r pressure in					+-+	_		t gain or loss		veight		
22 Have any allergies	1-	┢─	47. Palpit	ation or pou	Inding	g he	art					sive bleeding				
23 Take any medications regularly	1	T	48. Heart	trouble or h	eart	muri	mur			-	76. Tumo	r, growth, cy	st, or	cancer		
24. Stutter or stammer		Γ	49. High b	blood pressu	re						77. Consi	dered or atte	empt	ed suicide		
25 Wear a bone or joint brace or		Γ	50 Cough	ned up or vo	miteo	ыро	od				78. Sleep	walking epis	odes			
support			51. Stoma	ich, liver, or	intes	tinal	trou	ible			79. Easy	atigability				
C. Have you ever had or do you now have			52. Galibi	adder troub	le or	galls	tone	5			80. Car, t	rain, sea, or a	air sic	kness		LГ
26 Frequent, severe, or migraine		1		v jaundice o							81. X-ray	or other rad	iatio	n therapy		\square
headaches	┢	┞		rrhoids or re		lisea	se		\square			livity to chem	nicals	, dust,		
27 Fainting or dizzy spells	┢	┞	· · · · ·	or bloody st					+	Ц		ht, etc.		·····		┞╌┠╌
28 Periods of unconsciousness 29 Head injury or skull fracture	+	┞	· · · · · ·	ent or painfi			on		+	Щ		-		speech problems		
29 Head injury or skull fracture 30 Epilepsy, seizures, or convulsions	╞	+		etting since	-	_			+					Have you ever		
31 Loss of memory or amnesia	╋	┝	58. 81000 59. Kidne	, protein, or	auga		ar ine		╉┥			treated for a ul periods, oi		ale disorder, nps		
	+	┢	+	a or rupture					+			change in m				++
32 Depression, excessive worry or nervousness, anxiety		1		one or joint	trout	ole; I	burs	tis	+	\square				ou now pregnant		╉╌╂╌
33 Any mental condition or illness	1	\vdash	+	n bones or a					+					ls (If yes, give		
34 Frequent trouble sleeping	T	T	63 Steel	pins, plates,	or sta	aple	s in a	ny bones	\top			and product				
E. Have you ever					Yes	No	E.	(Contd.) Have you	ever							Yes No
 Been refused employment or been unable to hold a or stay in school because of: 	job						91	Received, is there provide the second								\prod
a. Inability to perform certain movements?					\Box		92	Had, or have you ev	ver bei	en a	dvised to h	ave, any surg	pical			\mathbf{H}
b Inability to assume certain positions?								operations?								
c Other medical reasons?							93	Consulted or been t								\square
89 Been rejected for or discharged from military service because of physical, mental or other reasons?	e –							healers, or other pro						es?		++
90 Been denied or rated up for life insurance?							_ ⁹⁴	Had any illness or in	njury c	,ine	inan thos	e aiready not	ied?			
DD Form 2492, MAR 87											DoD Exe	eption to	SEG	3 approved by GS	A/IRM	15 2.87

Figure 3-5. DD FORM 2492, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL HISTORY

REMARKS (Every "Yes" response in items 11 through 94 must be status of the condition. Continue on a separate sheet and attach to t	explained in the space below. Give dates and complete details including names of dou his form if additional space is needed 3	ctors and hospitals or clin	ics and the summer in
			1
	tion supplied by me and that it is true and complete to the best of		
	to furnish the Government a complete transcript of my medical	record for purpose	is of processing
my application for this employment or service.			
			100
TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE	DATE SIGN	EU
TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE	DATE SIGN	
TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE	DATE SIGN	
	SIGNATURE ED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONN		
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DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF DENTAL EXAMINATION Privacy Act Statement AUTHORITY: 10 USC 8012 and Executive Order 9397. PRINCIPAL PURPOSE: To update a medical file as part of the application process to a United States Service Acad Reserve Officer Training Corps (ROTC) Scholarship Program, or the Uniformed Ser University of Health Sciences (USUHS). ROUTINE USES: Used to determine medical acceptability for one or more of the Service Academies, ROT USUHS, Information will be released to authorized personnel involved in the selection pro The Social Security Number (SSN) is used for positive identification. DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection	
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USUHS, Information will be released to authorized personnel involved in the selection pro The Social Security Number (SSN) is used for positive identification. DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection	demy , rvices
process and hamper your candidacy.	ection
1. APPLICANT'S NAME (Last, First, Middle Initial) 2. SSN	
JONES, HARRY W., JR. 100-01-0001	
INSTRUCTIONS	
To be completed at scheduled Examining Center by the Examining Dentist. Panoramic and bitewing radiographs must accompany this examinat and be identified by name and SSN. Expedite completed Dental Examination with completed Medical Examination to: DODMERB/DB, US Acade Colorado Springs, Co 80840-6518.	aon my,
3. INDICATE ON THE CHART BELOW, RESTORABLE, NON-RESTORABLE, 4. TYPED OR PRINTED NAME OF EXAMINING DENTIST MISSING TEETH, TEETH REPLACED, SPACES CLOSED AND ANY DEFECTS OR	
ABNORMALITIES. (Do not chart restorations) MARK V. ALLEN, D.D.S.	
MANNA MILLA IN A MANNA S. SIGNATURE OF EXAMINING DENTIST 6. DATE	SIGNED
Marlvallen Gla	\sim
BERNUL WOODD	-07
TANK ALLING FACILITY	
a NAME	
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 Vandenberg Dental Clinic	
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 b. ADDRESS	
USAF Clinic/SGD Vandenberg AFB CA 93437-5300	
NOTE: If examinee has a guestionable occlusal relationship, forward diagnost	
	ic casts to:
US Academy Colorado Springs, CO 80840-6518	
GENERAL ("X" Yes or No for each question)	
YES NO	
X a. DENTAL CARIES (indicate on chart, do not chart incipiencies)	
b. MISSING TEETH, OTHER THAN THIRD MOLARS (indicate on chart by marking "X" through the roots). c. NON-RESTORABLE TEETH (indicate on chart by drawing two vertical lines through tooth).	
X C. NUN-RESTORABLE FEETH (indicate on chart by drawing two vertical lines through tooth). X d. UNERUPTED TEETH (draw circle around the tooth on the chart and indicate position by an arrow).	
e. DEVELOPMENTAL DISTURBANCES IN TEETH (significant enamel hypoplasias, amelogenesis imperfecta, dentinogenesis imperfecta, etc.).	
X f. STAINED TEETH (intrinsic) (unsightly)	
9. HISTORY OF ORAL DISEASE, TUMOR OR ANY OTHER ABNORMALITY OF THE ORAL CAVITY ("X" Yes or No for each question. If additional space is needed use "REMARKS" section.)	i
A. HAS THE EXAMINEE EVER HAD A CYST OR TUMOR REMOVED FROM THE MOUTH OR JAWS? (If so, describe.)	
b. HISTORY OF ABNORMAL BLEEDING OF THE ORAL TISSUES. (Describe)	
X c. ORAL ULCERATIONS, SOFT TISSUE LESIONS, ETC. (Describe)	
X e. HISTORY OF CLEFT PALATE.	
(1) If yes, is there an oro-nasal or oro-antral fistula present?	
Continued on reverse side)	ļ
DD Form 2480, NOV 86 Previous edition is obsolete. DoD exception to SF 603 approved by GSA/IR	MS 6-86
Figure 4-1. DD FORM 2480, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF DENTAL EXAMIN	

10. OCCLUSAL RELATIONSHIP ("x" Yes or No for each guestion) (if additional space is needed, use "REMARKS" section) YES NO	
X a. ANTERIOR VERTICAL OPEN BITE GREATER THAN 1mm.	
X b. ANTERIOR OVERBITE IN EXCESS OF 4mm.	
X c. ANTERIOR HORIZONTAL OVERJET IN EXCESS OF 4mm.	
d. SOFT TISSUE IMPINGEMENT OF THE LOWER ANTERIOR TEETH INTO THE HARD PALATE, OR THE UPPER ANTERI	OR TEETH
X e. ANTERIOR CROSSBITE. (Describe)	
X f. MANDIBULAR PROGNATHISM.	
X g. POSTERIOR OPEN BITE (bilateral involving more than one tooth). X h. POSTERIOR CROSSBITE (entire guadrant).	
X i. UNSIGHTLY CROWDING OF THE ANTERIOR TEETH.	
X J. MULTIPLE CONGENITALLY MISSING TEETH.	
X k. MIDLINE DEVIATION. 2 mm	
X I. ARE DENTAL STUDY CASTS BEING FORWARDED?	
11. ORTHODONTICS ("X" Yes or No for each question)	
X a. PAST HISTORY OF ORTHODONTIC TREATMENT (date completed) June 87	
X b. PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT (specify fixed or removable)	
X c. WEARING RETAINER APPLIANCES. 21 thru 27 fixed retainer	
12. PROSTHODONTICS ("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section.)	
X a. MISSING TEETH (prosthesis required). (Describe)	
X b. MISSING TEETH REPLACED BY AN UNSERVICEABLE PROSTHESIS. (Describe)	
X C. ARE THERE LESS THAN EIGHT, SERVICEABLE, NATURAL TEETH IN EACH ARCH?	
13. PERIODONTAL STATUS ("X" Yes or No for each question)	
X a. MODERATE TO HEAVY CALCULUS (supra and : or sub-gingival)	
X b. GINGIVITIS (generalized).	
X C. ACUTE NECROTIZING ULCERATIVE GINGIVITIS.	
X d. LOCAL OR GENERALIZED PERIODONTITIS (with associated bone loss).	
X f. PERICORONITIS.	
14. PANOGRAPHIC RADIOGRAPH EXAMINATION ("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section).	
X a. ABNORMAL RADIOLUCENT / RADIOPAQUE AREA. (Describe)	
X b. IMPACTED TEETH WITH PATHOLOGY. (Describe)	
X C. IMPACTED TEETH OTHER THAN THIRD MOLARS. (Describe)	
X d. OTHER RADIOGRAPHIC ABNORMALITIES. (Describe)	
15. OTHER ABNORMAL CONDITIONS OF THE ORAL CAVITY NOT PREVIOUSLY MENTIONED. ("X" Yes or No)	
16. REMARKS (Indicate item of reference.) (Use additional sheet if necessary.)	DODMERB USE ONLY
13a Patient needs prophylaxis and scaling.	

	DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF DENTAL EXAMINATION				
	Privacy Act State	ment			
AUTHORITY:	10 USC 8012 and Executive Order 9397.				
PRINCIPAL PURPOSE:	To update a medical file as part of the ap Reserve Officer Training Corps (ROTC) University of Health Sciences (USUHS).	pplication process to a United States Service Academ Scholarship Program, or the Uniformed Service	iy, es		
ROUTINE USES:	Used to determine medical acceptability USUHS, Information will be released to a The Social Security Number (SSN) is used for	for one or more of the Service Academies, ROTC, or uthorized personnel involved in the selection process for positive identification.	or ss.		
<u>DISCLOSURE</u> :	Voluntary; however, failure to furnish t process and hamper your candidacy.	the requested information will impede the selection	on		
1. APPLICANT'S NAME (Last, F	First, Middle Initial)	2. 55N			
To be completed at schedulec and be identified by name an Colorado Springs, Co 80840-6	d SSN. Expedite completed Dental Examination with o	mic and bitewing radiographs must accompany this examination completed Medical Examination to: DODMER8/D8, US Academy,			
3. INDICATE ON THE CHART	BELOW, RESTORABLE, NON-RESTORABLE, LACED, SPACES CLOSED AND ANY DEFECTS OR	4. TYPED OR PRINTED NAME OF EXAMINING DENTIST			
		5. SIGNATURE OF EXAMINING DENTIST 6. DATE SIGN 7. EXAMINING FACILITY a. NAME	VED		
RIGHT 32 31 30 29 20 32 31 30 20 30 30 30 30 30 30 30 30 30 30 30 30	LEFT	b. ADDRESS NOTE: If examinee has a questionable occlusal relationship, forward diagnostic cast DODMERB/DB US Academy Colorado Springs, CO 80840-6518	ts to:		
8. GENERAL ("X" Yes or No for ea YES NO	ich question)				
a. DENTAL CAR b. MISSING TEE c. NON-RESTOF d. UNERUPTED e. DEVELOPMEN f. STAINED TEE 9. HISTORY OF ORAL DISEA ("X" Yes or No for each question. a. HAS THE EX. b. HISTORY OF c. ORAL ULCER d. HISTORY OF e. HISTORY OF (1) If yes, is th	ILES (indicate on chart, do not chart incipiencies) TH, OTHER THAN THIRD MOLARS (indicate on chart by m RABLE TEETH (indicate on chart by drawing two vertical lines thro TEETH (draw circle around the tooth on the chart and indicate positi NTAL DISTURBANCES IN TEETH (significant enamel hypopla ETH (intrinsic) (unsightly). ISE, TUMOR OR ANY OTHER ABNORMALITY OF TH if additional space is needed use "REMARKS" section.) AMINEE EVER HAD A CYST OR TUMOR REMOVED I ABNORMAL BLEEDING OF THE ORAL TISSUES. (Desc (ATIONS, SOFT TISSUE LESIONS, ETC. (Describe) CLEFT LIP CLEFT PALATE. here an oro-nasal or oro-antral fistula present? TMJ DISEASE OR PAIN. (Describe)	nugh tooth). Ition by an arrow). asias, amelogenesis imperfecta, dentinogenesis imperfecta, etc.). IE ORAL CAVITY FROM THE MOUTH OR JAWS? (If so, describe.)			
DD Form 2480, NOV 86	Previous edition is obsolete.	DoD exception to SF 603 approved by GSA/IRMS	6-86		
Figure 4-3. DD FORM 2	2480, DOD MEDICAL EXAMINATION REVIEW	BOARD (DODMERB) REPORT OF DENTAL EXAMINAT	ION		

O. OCCUISAL RELATIONSHIP ("X" read with for each question (if additional space in medid, use "REMARKS" tection? VES NO A. ANTERIOR VERTICAL OPEN BITE GREATER THAN Imm A. ANTERIOR OVERBITE IN EXCESS OF 4mm. C. ANTERIOR CROSSBITE. Greates Interview ANTERIOR TEETH INTO THE HARD PALATE, OR THE UPPER ANTERIOR TEETH INTO THE LOWER LABIAL GUINE/VAE E. ANTERIOR OPEN BITE failure involving more than one tooth) A. POSTERIOR OPEN BITE failure involving for the ANTERIOR TEETH A. MULTIPLE CONGENITIC TREATMENT (Section) A. POSTERIOR OPEN BITE failure involving interving interv
b. ANTERIOR OVERBITE IN EXCESS OF 4mm. c. ANTERIOR HORIZONTAL OVERLET IN EXCESS OF 4mm. d. SOFT TSSUE INPINOEMENT OF THE LOWER ANTERIOR TEETH INTO THE HARD PALATE, OR THE UPPER ANTERIOR TEETH iNTO THE LOWER LABIAL GINGIVAE e. ANTERIOR CROSSBITE. (bearbed f. MANDIBULAR PROGNATHISM g. POSTERIOR OPEN BITE (bilateral involving more than one (noth) h. POSTERIOR CROSSBITE (centre underant) i. UNSIGHTLY (CROWDING OF THE ANTERIOR TEETH. i. MULTIPLE CONGENITALLY MISSING TEETH. i. ARE DEVIAL STUDY CASTS BEING FORWARDED? 1. ORTHODONTICS ("X" Yes in ho for each question) a. PAST HISTORY OF ORTHODONTIC TREATMENT (dure completed) b. PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT (greatly fixed or removable) c. WEARING RETAINER APPLIANCES 2. PROSTHODONTICS ("X" Yes in ho for each question) (# additional space is needed use "#KMARKS" section.) a. MISSING TEETH (prosthedir question) (# additional space is needed use "#KMARKS" section.) a. MISSING TEETH REPLACED BY AN UNSERVICEABLE PROSTHESIS (describe) c. ARE THERE LESS THANE REGHT, SERVICEABLE PROSTHESIS (describe) c. ARE THERE LESS THANE REGHT, SERVICEABLE PROSTHESIS (describe) c. ACUTE NECROTIZING ULCERATIVE GINGIVITIS d. I.OCAL OR GENERALUZED PERIODONTICS c. TY ear on for each question) a. MODERATE TO HEAVY CALCULUS topics and or uningingual b. GINGVITIS (greateriated) c. ACUTE NECROTIZING ULCERATIVE GINGIVITIS d. LOCAL OR GENERALUZED PERIODONTICS c. MIDERALEZED PERIODONTICS c. TY ear on for each question) a. MODERATE TO HEAVY CALCULUS topics and or uningingual b. GINGVITIS (greateriated) c. ACUTE NECROTIZING ULCERATIVE GINGIVITIS d. LOCAL OR GENERALUZED PERIODONTICS c. ACUTE NECROTIZING ULCERATIVE GINGIVITIS d. LOCAL OR GENERALUZED PERIODONTICS c. MIDERALEZED
C. ANTERIOR HORIZONTAL OVERLET IN EXCESS OF 4mm. G. SOFT TISSUE IMPINGEMENT OF THE LOWER ANTERIOR TEETH INTO THE HARD PALATE, OR THE UPPER ANTERIOR TEETH INTO THE LOWER LABILA ENOIVAE ANTERIOR CROSSBITE. (Describe) F. MANDBULAR PROGNATHISM G. POSTERIOR OPEN BITE dilated involving more than one tooth) h. POSTERIOR OPEN BITE dilated involving more than one tooth) h. POSTERIOR OPEN BITE dilated involving more than one tooth) h. POSTERIOR OPEN BITE dilated involving more than one tooth) h. POSTERIOR OPEN BITE dilated involving more than one tooth) h. POSTERIOR OPEN BITE dilated involving more than one tooth) h. POSTERIOR OPEN BITE dilated involving more than one tooth) h. POSTERIOR OPEN BITE dilated involving more than one tooth) h. POSTERIOR OPEN BITE dilated involving more than one tooth) h. POSTERIOR OPEN BITE dilated involving more than one tooth) h. POSTERIOR OPEN BITE dilated involving more than one tooth) h. POSTERIOR OPEN BITE dilated involving more than one tooth) h. POSTERIOR OPEN BITE dilated involving more than one tooth) h. POSTERIOR OPEN BITE dilated involving more than one tooth) h. POSTERIOR OPEN BITE dilated involving the dilated involving more than one tooth) h. POSTERIOR OPEN BITE dilated involving the dilated involving more than one tooth) h. POSTERIOR OPEN BITE dilated involving the dilated involving th
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INTO THE LOWER LABIAL GINGIVAE. e. ANTERIOR CROSSBITE. (parenta) f. MANDIBULAR PROGNATHISM. g. POSTERIOR OPEN BITE (plateral involving more than one tooth) f. MANDIBULAR PROGNATHISM. g. POSTERIOR CROSSBITE (entire guadrant). i. UNSIGHTLY CROWDING OF THE ANTERIOR TEETH j. MULTIPLE CONGENITALLY MISSING TEETH. k. MIDLINE DEVIATION. i. ARE DENTAL STUDY CASTS BEING FORWARDED? ORTHODONTICS ("X" vision for and question) a. PAST HISTORY OF ORTHODONTIC TREATMENT (date completed) b. PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT (specify fixed or removable). c. WEARING RETAINER APPLIANCES PROSTHODONTICS ("X" vision for each question) (If additional space is needed use "#EMARKS" section.) a. MISSING TEETH (prostness required) (Costnbe) b. MISSING TEETH (prostness required) (Costnbe) c. ARE THERE LESS THAN EIGHT, SERVICEABLE, NATURAL TEETH IN EACH ARCH? c. ARE THERE LESS THAN EIGHT, SERVICEABLE, NATURAL TEETH IN EACH ARCH? d. DINGIVITIS (generalized) d. DINGIVITIS (with associater blone loss) d. DINGIVITIS (preventing) d. LOCAL OR GENERALIZED PERIODONTITIS d. LOCAL OR GENERALIZED PERIODONTITIS (with associater blone loss) e. JUVENILE PERIODONTITIS. t. PERICORONITIS. t. PERICOR
f. MANDIBULAR PROGNATHISM. g. POSTERIOR OPEN BITE (bilateral involving more than one tooth) h. POSTERIOR CROSSBITE (curre quadrant) i. UNSIGHTLY CROWDING OF THE ANTERIOR TEETH. j. MULTIPLE CONCENTRALLY MISSING TEETH. k. MIDLINE DEVIATION. i. ARE DENTAL STUDY CASTS BEING FORWARDED? 1. ARE DENTAL STUDY CASTS BEING FORWARDED? a. PAST HISTORY OF ORTHODONTIC TREATMENT (date completed). b. PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT (date completed). c. WEARING RETAINER APPLIANCES. 2. PROSTHODONTICS ("x" ves or No for each question) a. MISSING TEETH (proxthesis required) (decide) b. PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT (geedly fixed or removable). c. WEARING RETAINER APPLIANCES. 2. PROSTHODONTICS ("x" ves or No for each question) (if additional space is needed. use "REMARKS" section) a. MISSING TEETH (proxthesis required) (decide) b. MISSING TEETH REPLACED BY AN UNSERVICEABLE PROSTHESIS (describe) c. ARE THERE LESS THAN EIGHT. SERVICEABLE, NATURAL TEETH IN EACH ARCH? 3. PERIODONTAL STATUS ("x" ves or No for each question) a. MODERATE TO HEAVY CALCULUS (pupper and or tub-ginginal) b. GINIGUITIS (generalized) c. ACUTE NECROTIZING ULCERATIVE GINGIVITIS d. LOCAL OR GENERALIZED PERIODONTITIS (with associated bone loss) e. JUVENILE PERIODONTITIS. f. PERIODONTIS. 4. PANOGRAPHIC RADIOGRAPH EXAMINATION ("x" ves or No for each question) (if additional space is needed, use "REMARKS" section) a. BABORMAL RADIOLOUCENT / RADIOPAQUE AREA. (Describe) b. J
f. MANDIBULAR PROGNATHISM. g. POSTERIOR OPEN BITE (bilateral involving more than one tooth) h. POSTERIOR CROSSBITE (curre quadrant) i. UNSIGHTLY CROWDING OF THE ANTERIOR TEETH. j. MULTIPLE CONCENTRALLY MISSING TEETH. k. MIDLINE DEVIATION. i. ARE DENTAL STUDY CASTS BEING FORWARDED? 1. ARE DENTAL STUDY CASTS BEING FORWARDED? a. PAST HISTORY OF ORTHODONTIC TREATMENT (date completed). b. PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT (date completed). c. WEARING RETAINER APPLIANCES. 2. PROSTHODONTICS ("x" ves or No for each question) a. MISSING TEETH (proxthesis required) (decide) b. PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT (geedly fixed or removable). c. WEARING RETAINER APPLIANCES. 2. PROSTHODONTICS ("x" ves or No for each question) (if additional space is needed. use "REMARKS" section) a. MISSING TEETH (proxthesis required) (decide) b. MISSING TEETH REPLACED BY AN UNSERVICEABLE PROSTHESIS (describe) c. ARE THERE LESS THAN EIGHT. SERVICEABLE, NATURAL TEETH IN EACH ARCH? 3. PERIODONTAL STATUS ("x" ves or No for each question) a. MODERATE TO HEAVY CALCULUS (pupper and or tub-ginginal) b. GINIGUITIS (generalized) c. ACUTE NECROTIZING ULCERATIVE GINGIVITIS d. LOCAL OR GENERALIZED PERIODONTITIS (with associated bone loss) e. JUVENILE PERIODONTITIS. f. PERIODONTIS. 4. PANOGRAPHIC RADIOGRAPH EXAMINATION ("x" ves or No for each question) (if additional space is needed, use "REMARKS" section) a. BABORMAL RADIOLOUCENT / RADIOPAQUE AREA. (Describe) b. J
h. POSTERIOR CROSSBITE (entire quadrant). i. UNSIGHTLY CROWDING OF THE ANTERIOR TEETH. j. MULTIPLE CONGENITALLY MISSING TEETH. k. MIDDINE DEVIATION. l. ARE DENTAL STUDY CASTS BEING FORWARDED? 1. ORTHODONTICS ("X" yes or No for each question) a. PAST HISTORY OF ORTHODONTIC TREATMENT (date completed) b. PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT (green/prined) c. WEARING RETAINER APPLIANCES. 2. PROSTHODONTICS ("X" yes or No for each question) (fedditional space is needed, use "REMARKS" section.) a. MISSING TEETH (prostness required) (Operche) b. MISSING TEETH REPLACED BY AN UNSERVICEABLE PROSTHESIS (pescribe) c. ARE THERE LESS THAN EIGHT, SERVICEABLE, NATURAL TEETH IN EACH ARCH? 3. PERIODONTAL STATUS ("X" yes or No for each question) a. MODERATE TO HEAVY CALCULUS (supra and or sub-gingsall b. GINGIVITIS (generalized) c. ALUTE NECROTIZING ULCERATIVE GINGIVITIS. d. LOCAL OR GENERALIZED PERIODONTITIS (with associated bone loss) e. JUVENILE PERIODONTITIS. f. PERICORONITIS. 4. PANOGRAPHIC RADIOGRAPH EXAMINATION ("X" yes or No for each question) (ff additional space is needed. use "REMARKS" section).
k. MIDLINE DEVIATION. 1. ARE DENTAL STUDY CASTS BEING FORWARDED? 1. ORTHODONTICS ("X" yes or No for each question) a. PAST HISTORY OF ORTHODONTIC TREATMENT (date completed) b. PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT (greatly fixed or removable). c. WEARING RETAINER APPLIANCES 2. PROSTHODONTICS ("X" yes or No for each question) (If additional space is needed. use "REMARKS" section.) a. MISSING TEETH (prosthesis required) (Describe) b. MISSING TEETH REPLACED BY AN UNSERVICEABLE PROSTHESIS. (Describe) c. ARE THERE LESS THAN EIGHT, SERVICEABLE, NATURAL TEETH IN EACH ARCH? 3. PERIODONTAL STATUS ("X" Yes or No for each question) a. MODERATE TO HEAVY CALCULUS (supra and i or sub-gingval) b. GINGIVITIS (generalized) c. ACUTE NECROTIZING ULCERATIVE GINGIVITIS. d. LOCAL OR GENERALIZED PERIODONTITIS (with associated bone loss) e. JUVENILE PERIODONTITIS. f. PERICORONITIS. A. PANOGRAPHIC RADIOGRAPH EXAMINATION ("X" yes or No for each question) (If additional space is needed. use "REMARKS" section). a. ABNORMAL RADIOLUCENT / RADIOPAQUE AREA. (Describe) b. IMPACTED TEETH OTHER THAN THIRD MOLARS. (Describe) c. ACUTE NECRONITIS.
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b. PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT (specify fixed or removable). c. WEARING RETAINER APPLIANCES. 2. PROSTHODONTICS ("X" yes or No for each question) (If additional space is needed, use "REMARKS" section.) a. MISSING TEETH (prosthesis required) (Describe) b. MISSING TEETH (prosthesis required) (Describe) c. ARE THERE LESS THAN EIGHT, SERVICEABLE PROSTHESIS. (Describe) c. ARE THERE LESS THAN EIGHT, SERVICEABLE, NATURAL TEETH IN EACH ARCH? 3. PERIODONTAL STATUS ("X" yes or No for each question) a. MODERATE TO HEAVY CALCULUS (supra and : or tub: gingival) b. GINGIVITIS (generalized). c. ACUTE NECROTIZING ULCERATIVE GINGIVITIS. d. LOCAL OR GENERALIZED PERIODONTITIS (with associated bone loss) e. JUVENILE PERIODONTITIS. f. PERCORONITIS. 4. PANOGRAPHIC RADIOGRAPH EXAMINATION ("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section) a. ABNORMAL RADIOLUCENT / RADIOPAQUE AREA. (Describe) b. IMPACTED TEETH WITH PATHOLOGY. (Describe) c. IMPACTED TEETH HIN THAN THIRD MOLARS. (Describe) d. OTHER RADIOGRAPHIC ABNORMALITIES. (Describe)
c. WEARING RETAINER APPLIANCES. 2. PROSTHODONTICS ("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section.) a. MISSING TEETH (prosthesis required) (Describe) b. MISSING TEETH REPLACED BY AN UNSERVICEABLE PROSTHESIS. (Describe) c. ARE THERE LESS THAN EIGHT, SERVICEABLE, NATURAL TEETH IN EACH ARCH? 3. PERIODONTAL STATUS ("X" Yes or No for each question) a. MODERATE TO HEAVY CALCULUS (supra and r or sub-gringival) b. GINGIVITIS (generalized). c. ACUTE NECROTIZING ULCERATIVE GINGIVITIS. d. LOCAL OR GENERALIZED PERIODONTITIS (with associated bone loss) e. JUVENILE PERIODONTITIS. f. PERICORONITIS. 4. PANOGRAPHIC RADIOGRAPH EXAMINATION ("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section). a. ABNORMAL RADIOLUCENT / RADIOPAQUE AREA. (Describe) b. IMPACTED TEETH WITH PATHOLOGY. (Describe) c. IMPACTED TEETH WITH PATHOLOGY. (Describe) d. OTHER RADIOGRAPHIC ABNORMALITIES. (Describe) d. OTHER RADIOGRAPHIC ABNORMALITIES. (Describe)
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 c. ACUTE NECROTIZING ULCERATIVE GINGIVITIS. d. LOCAL OR GENERALIZED PERIODONTITIS (with associated bone loss) e. JUVENILE PERIODONTITIS. f. PERICORONITIS. 4. PANOGRAPHIC RADIOGRAPH EXAMINATION ("x" yes or No for each question) (If additional space is needed, use "REMARKS" section). a. ABNORMAL RADIOLUCENT / RADIOPAQUE AREA. (Describe) b. IMPACTED TEETH WITH PATHOLOGY. (Describe) c. IMPACTED TEETH OTHER THAN THIRD MOLARS. (Describe) d. OTHER RADIOGRAPHIC ABNORMALITIES. (Describe)
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e. JUVENILE PERIODONTITIS. f. PERICORONITIS. a. PANOGRAPHIC RADIOGRAPH EXAMINATION ("x" yes or No for each question) (If additional space is needed, use "REMARKS" section). a. ABNORMAL RADIOLUCENT / RADIOPAQUE AREA. (Describe) b. IMPACTED TEETH WITH PATHOLOGY. (Describe) c. IMPACTED TEETH OTHER THAN THIRD MOLARS. (Describe) d. OTHER RADIOGRAPHIC ABNORMALITIES. (Describe)
f. PERICORONITIS. 4. PANOGRAPHIC RADIOGRAPH EXAMINATION ("x" yes or No for each question) (If additional space is needed, use "REMARKS" section). a. ABNORMAL RADIOLUCENT / RADIOPAQUE AREA. (Describe) b. IMPACTED TEETH WITH PATHOLOGY. (Describe) c. IMPACTED TEETH OTHER THAN THIRD MOLARS. (Describe) d. OTHER RADIOGRAPHIC ABNORMALITIES. (Describe)
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b. IMPACTED TEETH WITH PATHOLOGY. (Describe) c. IMPACTED TEETH OTHER THAN THIRD MOLARS. (Describe) d. OTHER RADIOGRAPHIC ABNORMALITIES. (Describe)
b. IMPACTED TEETH WITH PATHOLOGY. (Describe) c. IMPACTED TEETH OTHER THAN THIRD MOLARS. (Describe) d. OTHER RADIOGRAPHIC ABNORMALITIES. (Describe)
c. IMPACTED TEETH OTHER THAN THIRD MOLARS. (Describe) d. OTHER RADIOGRAPHIC ABNORMALITIES. (Describe)
d. OTHER RADIOGRAPHIC ABNORMALITIES. (Describe)
6. REMARKS (Indicate item of reference.) (Use additional sheet if necessary.) DODMERB USE ONLY

Figure 4-4. DD FORM 2480 Reverse, NOV 86

ITEM-BY-ITEM EXPLANATION FOR FILLING OUT DD FORM 2480

Explanation	Model Entry
Item 1. Applicant Name. (Last, First, MI)	Jones, Harry W., Jr.
Item 2. Social Security Number.	999–99–9999
Item 3. Indicate on the chart: Restorable, nonrestorable, missinging teeth, teeth replaced, spaces closed and any defects or abnormalities. Do not chart restorations.	See item 3, attachment 4
Item 4. Typed or Printed Name of Examining Dentist.	CHARLES P. WHITE, Maj, USAF, DC
Item 5 and 6. Signature of Examining Dentist and Date of Dental Examination.	Self-explanatory
Item 7. Examining Facility and Address.	USAF Clinic/SGD Vandenberg AFB CA 93437–5300
Item 8 through 15. A yes or no answer is required for each of the questions. Write in additional information next to the question or in the remarks section (item 16).	See items 8 through 15, attachment 4
Item 16. Remarks. Indicate item of reference, use additional sheet if necessary.	Item 13a. Patient needs prophylaxis and scaling.

Figure 2-1. ITEM-BY-ITEM EXPLANATION FOR FILLING OUT DD FORM 2480

····· · · · · · · · · · · · · · · · ·		LOPLEGIC REFRACTIO	
· · · · · · · · · · · · · · · · · · ·		Privacy Act Statement	
AUTHORITY:	Title 10, USC 122, and	d Executive Order 9397.	
PRINCIPAL PURPOSE:		ps (ROTC) Scholarship Programs	process to a US Service Academy, Reserv , or the Uniformed Services University of
ROUTINE USE:	USUHS. Information		re of the service academies, ROTC O ed personnel involved in the selectio positive identification.
DISCLOSURE:	Voluntary, however, process and hamper		ed information will impede the selectio
. NAME OF APPLICANT (La	st, First, Middle Initial)	2. SSN OF APPLICANT	3. DATE OF EXAMINATION
SCARBOROUGH, JIM	MY R	001-00-1000	5 May 87
. ADDRESS OF FACILITY (USAFA HOSPITAL/S USAFA, CO 80840	ity, State, Zip Code) GP	I	5. PHONE NO. AT FACILITY (Include Area Code (303) 472-3577
CONTACT LENS DATA (X	Applicable Item(s))		7. FAMILY EYE HISTORY (Please indicate the
X a. I do not wear cont			members of your immediate family who wear glasses of contact lenses.) (X applicable item(s))
b. Soft contact lenses		days prior to the above examination	X a. Father
c. Hard contact lenses		days prior to the above examination	b. Mother
d. Signature of Applic	ant		c. Brother
			X d. Sister
VISION EVALUATION BEI	ORE INSTALLATION OF DRO	PS (Refore cycloplegic)	e. None of my family
DISTANT VISION		b. CURRENT RX N/A	
OD 20/ 20	Corr to 20/	OD Sphere	Cyl Axis
OS 20/ 20	Corr to 20/	OS Sphere	Cyl Axis
NEAR VISION		9. MEDICATION USED FOR	
OD 20/ 20	Corr to 20/	Cyclogel	
OS 20/ 20	Corr to 20/	_	
			of letters missed on 20/20, i.e., 20/20-2; 20/20-3 etc. If unable to
	table vision. Do <u>not</u> over correct; corre		
DISTANT VISION CORREC		b. CYCLO RX	
OD 20/ 50	Corr to 20/ 15	OD Sphere +0.50	Cyl -0.50 Axis 088
OS 20/ 50	Corr to 20/ 15	OS Sphere +0,50 Isual function which was noted on this examination.	Cyl -0.25 Axis 090
2. TYPED OR PRINTED NA	ME OF EXAMINER	13. SIGNATURE OF	EXAMINER

		AL EXAMINATION REVIEW BOARD	
	······································	Privacy Act Statement	
AUTHORITY:	Title 10, USC 122	2, and Executive Order 9397.	
PRINCIPAL PURPOSE:		g Corps (ROTC) Scholarship Program	n process to a US Service Academy, Reserve is, or the Uniformed Services University of
ROUTINE USE:	To determine n USUHS. Inform	nedical acceptability for one or m	ore of the service academies, ROTC OR zed personnel involved in the selection
DISCLOSURE:	Voluntary, how	•	ted information will impede the selection
1. NAME OF APPLICANT (Las	st, First, Middle Initial)	2. SSN OF APPLICANT	3. DATE OF EXAMINATION
4. ADDRESS OF FACILITY (C	ity, State, Zip Code)		5. PHONE NO. AT FACILITY (include Area Code)
6. CONTACT LENS DATA (XA	Applicable (tem/c))		7. FAMILY EYE HISTORY (Please indicate the
a. I do not wear conta			members of your immediate family who wear glasses or
b. Soft contact lenses v		days prior to the above examination	contact lenses.) (X applicable item(s)) a. Father
c. Hard contact lenses		days prior to the above examination	b Mother
d. Signature of Applica			c. Brother
			d. Sister
			e. None of my family
VISION EVALUATION BEF	ORE INSTALLATION O		e. None of my family
	UNE INSTALLATION O		
DISTANT VISION		b. CURRENT RX	
OD 20/	Corr to 20/	OD Sphere	Cyl Axis
OS 20/	Corr to 20/	OS Sphere	Cyl Axis
NEAR VISION		9. MEDICATION USED FOR	CYCLOPLEGIC
OD 20/	Corr to 20/		
OS 20/	Corr to 20/	I	
			er of letters missed on 20/20, i.e., 20/20-2; 20/20-3 etc. If unable to
correct to 20/20, record best correc			
a. DISTANT VISION CORREC	· · · · · · · · · · · · · · · · ·	b. CYCLO RX	
OD 20/	Corr to 20/	OD Sphere	Cyl Axis
OS 20/	Corr to 20/	OS Sphere es with visual function which was noted on this examination	<u>Cyl</u> Axis
		·	
12. TYPED OR PRINTED NA	ME OF EXAMINER	13. SIGNATURE OF	EXAMINER

T		D MEDICAL EXAMINATION			
		Privacy Act	Statement		
AUTHORITY:	Title 10, L	ISC 133, 3012, 5031, 8012 ar	nd Executive Order	9397.	
PRINCIPAL PURPOSE:	Officer T	e a medical file as part of raining Corps (ROTC) Scho iences (USUHS).	the application pr larship Programs,	rocess to a US Service A or the Uniformed Servi	Academy, Reserve ices University of
ROUTINE USES:	To deterr Informati	nine medical acceptability on will be released to aut urity number (SSN) is used f	thorized personnel	involved in the select	ROTC or USUHS ion process. The
DISCLOSURE:	Voluntary; however, failure to furnish the requested information will impede the selecti process and hamper your candidacy.				ede the selection
1. NAME OF APPLICANT (La	st, First, Middle Ir	itial)	2. SSN 0	FAPPLICANT	
MARTINEZ CATHER	INE L		512-10	-0000	
		INSTRUCTIONS	TO EXAMINERS	······································	
patient's arm. If it is t may be erroneously lo	oo narrow w. For the ff, 18 to 20	e sphygmomanometer cuff , the blood pressure readir average adult, a cuff 12 to cm wide, must be used. WIDTH OF THE BLOOD	ngs will be erroned o 14 cm wide is sat	ously high. If it is too w	ride, the readings mference greater
9"		PRESSURE CUFF 14 cm	NONE		
6. BLOOD PRESSURE AND	PULSE READ		Hould		
a. DAY ONE					
(1) DATE 5 May 87		(2) A.M. 0700 BLOOD PRESSURE	PULSE	(3) P.M. 1300 BLOOD PRESSURE	PULSE
(a) SITTING		136/80	80	140/86	88
(b) RECUMBENT		138/78	78	130/80	80
(c) STANDING		130/80	78	138/82	86
DAY TWO			······································		
(1) DATE 6 May 87		(2) A.M. 0715 BLOOD PRESSURE	PULSE	(3) P.M. 1400 BLOOD PRESSURE	PULSE
(a) SITTING		120/80	80	130/70	76
(b) RECUMBENT		120/76	76	126/70	76
(c) STANDING		126/82	80	132/80	80
C DAY THREE			·	/2) 044 1500	
(1) DATE 7 May 87		(2) A.M. 0730 BLOOD PRESSURE	PULSE	(3) P.M. 1500 BLOOD PRESSURE	PULSE
(a) SITTING		120/76	76	130/80	76
(b) RECUMBENT		118/80	76	130/80	74
(c) STANDING		124/80	80	136/86	80
7. EXAMINER (Doctor/Nurse/Pail a. TYPED OR PRINTED NAT			5. SIGNATURE		
MEDIC, JOHNNY D	vic (Last, First, N	naare Initial)		- Danadi	
c. TITLE AlC, Blood Pres	sure Rec	neck Department		J	

Figure 6-1. DD FORM 2370, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) THREE-DAY BLOOD PRESSURE AND PULSE CHECK

1		DICAL EXAMINATION			
		Privacy Act	t Statement		
AUTHORITY:	Title 10, USC 1	33, 3012, 5031, 8012 a	nd Executive Orde	9397.	
PRINCIPAL PURPOSE:	To update a n Officer Trainir Health Science	ig Corps (ROTC) Scho	the application p larship Programs,	rocess to a US Service A or the Uniformed Servi	cademy, Reserve ces University of
ROUTINE USES:	Information w	medical acceptability ill be released to au number (SSN) is used f	thorized personne	f the service academies, I involved in the selecti cation	ROTC or USUHS on process. The
DISCLOSURE:	Voluntary; ho	Voluntary; however, failure to furnish the requested information will impede the select process and hamper your candidacy.			
1. NAME OF APPLICANT (La	st, First, Middle Initial)	<u>, , , , , , , , , , , , , , , , , </u>	2. SSN C	F APPLICANT	
	·	INSTRUCTIONS	TO EXAMINERS	 	<u> </u>
patient's arm. If it is t may be erroneously lo than 28 cm a larger cu 3. ARM CIRCUMFERENCE	w. For the aver ff, 18 to 20 cm w 4. WIDT	age adult, a cuff 12 to	o 14 cm wide is sat	ously high. If it is too wi isfactory. For arm circur IRRENTLY TAKEN (If none, so state	nference greater
5. BLOOD PRESSURE AND	PULSE READINGS		1		
DAY ONE		- T			
(1) DATE		(2) A.M. BLOOD PRESSURE	PULSE	(3) P.M. BLOOD PRESSURE	PULSE
(a) SITTING			1		
(b) RECUMBENT					
(c) STANDING					
DAY TWO					
1) DATE		(2) A.M.	1	(3) P.M.	
(a) SITTING		BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE
(b) RECUMBENT					
(c) STANDING					
DAY THREE				╺╼╍┸╍╍╍╍╍╍╍╍╍╍╍	
(1) DATE		(2) A.M. BLOOD PRESSURE	PULSE	(3) P.M. BLOOD PRESSURE	PULSE
(a) SITTING					
(b) RECUMBENT					
(c) STANDING					<u> </u>
7. EXAMINER (Doctor/Nurse/Par					
a TYPED OR PRINTED NAN	AE (Last, First, Middle Init	()a)	b. SIGNATURE		
c TITLE				n <u></u>	

Figure 6-2. DD FORM 2370 Reverse, MAY 85

	UPDATE OF APPLICANT'S		
		<u>t Statement</u>	
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012	and Executive Order 939	37 .
PRINCIPAL PURPOSE:			is to a U.S. Service Academy, Reserve he Uniformed Services University of
ROUTINE_USE:		uthorized personnel inv	e service academies, ROTC or USUHS. Folved in the selection process. The ion.
DISCLOSURE:	Voluntary; however, failure to fi process and hamper your candidate		ormation will impede the selection
1. TYPED OR PRINTED NA	ME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT	3. NAME OF PROGRAM APPLIED FOR
LEWIS, JOHN D.		001-01-1001	US Naval Academy
medical examinati	hat I have not received any medic		
T	nt (X one)	<u></u>	
(1) IS TRUE AND	nt (X one)	elow.)	
(1) IS TRUE AND XX (2) IS NOT TOTA b. Detailed explanation	nt (X one) ACCURATE in all respects. LLY ACCURATE (Explain in detail in 4b b on why the statement in 4 above is n	ot totally accurate (Attac	
XX (2) IS NOT TOTA b. Detailed explanation I had two wisdom	nt (X one) ACCURATE in all respects. LLY ACCURATE (Explain in detail in 4b b	ot totally accurate (Attac	

EXAMINATION

	DOD MEDICAL EXAMINATIO		
	Privacy A	ct Statement	
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012	and Executive Order 9397	•
PRINCIPAL PURPOSE:	To upgrade a medical file as part o Officer Training Corps (ROTC) Sch Health Sciences (USUHS).	of the application process nolarship Programs, or the	to a U.S. Service Academy, Reserve Uniformed Services University of
<u>ROUTINE USE</u> :	To determine medical acceptability Information will be released to a Social Security number (SSN) is use	uthorized personnel invol	ervice academies, ROTC or USUHS. lved in the selection process. The n.
DISCLOSURE:	Voluntary; however, failure to fu process and hamper your candidate		mation will impede the selection
1. TYPED OR PRINTED NAN	ME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT	3. NAME OF PROGRAM APPLIED FOR
			le <u>ne ne ne ne</u> ne
Service Academy medic year's selection cycle. previous examination re	al examination report. Our records	indicate that you were gi ur medical or dental cond our medical or dental statu	
a. The above statemer	n."	al or dental care since the	ate of my service Academy
(1) IS TRUE AND	ACCURATE in all respects.		
(2) IS NOT TOTAL	LY ACCURATE (Explain in detail in 4b b	elow.)	
b. Detailed explanatio	n why the statement in 4 above i <mark>s n</mark>	ot totally accurate (Attach a	additional pages, if necessary.)
- 			
5. SIGNATURE OF APPLICAN	т		6. DATE SIGNED
DD Form 2371 MAY 85			

Figure 7-2. DD FORM 2371 Reverse, MAY 85

	Privacy Act Statement	
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executive	e Order 9397.
PRINCIPAL PURPOSE:	To update a medical file as part of the applicat Officer Training Corps (ROTC) Scholarship Prog Health Sciences (USUHS).	ion process to a U.S. Service Academy, Reserve
ROUTINE USE:	To determine medical acceptability for one or m Information will be released to authorized per Social Security number (SSN) is used for positive i	rsonnel involved in the selection process. The
DISCLOSURE:	Voluntary; however, failure to furnish the req process and hamper your candidacy.	uested information will impede the selection
1. NAME OF APPLICANT (La	ast, First, Middle Initial)	2. SSN OF APPLICANT
STEWART, ANN M.		001-02-1002
3. STATEMENT OF PRESENT	THEALTH	· · · · · · · · · · · · · · · · · · ·
Good.		***************************************
4. NAME OF MEDICATION	S) AND REASON FOR TAKING (If you are not on any kind of medications	s, simply state "NONE.")
Tetracycline for	r my acne.	
Tetracycline for	r my acne.	
Tetracycline for	r my acne.	
Tetracycline for	r my acne.	
Tetracycline for	r my acne.	
		rite "NONE")
	r my acne. ES? (Answer Yes or No. If yes, indicate treatment received; if no allergies, wr	rite "NONE.")
		rite "NONE.")
5. DO YOU HAVE ALLERGI		rite "NONE.")
5. DO YOU HAVE ALLERGI		rite "NONE.")
5. DO YOU HAVE ALLERGI		rite "NONE.")
5. DO YOU HAVE ALLERGI		rite "NONE.")
5. DO YOU HAVE ALLERGI		rite "NONE.")
5. DO YOU HAVE ALLERGI		rite "NONE.")
5. DO YOU HAVE ALLERGI		rite "NONE.")
5. DO YOU HAVE ALLERGI		rite "NONE.")
5. DO YOU HAVE ALLERGI		rite "NONE.")
5. DO YOU HAVE ALLERGI		rite "NONE.")
5. DO YOU HAVE ALLERGI		rite "NONE.")
5. DO YOU HAVE ALLERGI	ES? (Answer Yes or No. If yes, indicate treatment received, if no allergies, wr	rite "NONE.") 8. DATE SIGNED
	ES? (Answer Yes or No. If yes, indicate treatment received; if no allergies, wr	

	DOD MEDICAL EXAMINATION REVIEW BOARD (DODM STATEMENT OF PRESENT HEALTH	IERB)
	Privacy Act Statement	
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.	
PRINCIPAL PURPOSE:	To update a medical file as part of the application process to Officer Training Corps (ROTC) Scholarship Programs, or the Health Sciences (USUHS).	
ROUTINE USE:	To determine medical acceptability for one or more of the se Information will be released to authorized personnel involv Social Security number (SSN) is used for positive identification	ved in the selection process. The
DISCLOSURE:	Voluntary; however, failure to furnish the requested infor process and hamper your candidacy.	mation will impede the selection
1. NAME OF APPLICANT (La	st, First, Middle Initial)	2. SSN OF APPLICANT
3. STATEMENT OF PRESENT	HEALTH	
4. NAME OF MEDICATION(S) AND REASON FOR TAKING (If you are not on any kind of medications, simply state "NONE	<i>"</i>)
		· · · · · · · · · · · · · · · · · · ·
<u>n </u>		
5. DO YOU HAVE ALLERGI	ES? (Answer Yes or No. If yes, indicate treatment received; if no allergies, write "NONE")	
		· · · · · · · · · · · · · · · · · · ·
6. REMARKS		
		· · · · · · · · · · · · · · · · · · ·
7. SIGNATURE OF APPLICA	NT	8. DATE SIGNED
DD Form 2372, FEB 86	Previous edition may be used.	l
	Figure 8-2. DD FORM 2372 Reverse, FEB 86	

		MINATION REVIEW BOARD (DODMERI	3)
	<u><u>Pi</u></u>	rivacy Act Statement	
AUTHORITY:	Title 10, USC 133, 3012, 50	031, 8012 and Executive Order 9397.	
<u>PRINCIPAL PURPOSE</u> :	To update a medical file of Officer Training Corps (R Health Sciences (USUHS).	as part of the application process to a OTC) Scholarship Programs, or the Un	U.S. Service Academy, Reserv iformed Services University (
<u>ROUTINE USE</u> :	Information will be relea	ceptability for one or more of the services ased to authorized personnel involved N) is used for positive identification.	e academies, ROTC or USUH in the selection process. Th
DISCLOSURE:	Voluntary; however, fails process and hamper your	ure to furnish the requested informat candidacy.	ion will impede the selectic
1. NAME OF APPLICANT (Las	it, First, Middle Initial)		2. SSN OF APPLICANT
MALIK, BONITA A			111-11-1111
······································	INSTR	UCTIONS TO EXAMINER	L
of "innocent" or "func Defense Medical Exami	tional" murmurs. We require nation Review Board to ma	icuspid aortic valve are being found inc est that you complete this form which ke a proper determination of the appli	will enable the Department
3. GRADE, AMPLITUDE OR I		4. LOCATION (Where is the sound heard be:	st?)
Grade I/VI Systo	lic Murmur	Apex	
6. CHARACTER OF THE SOU Decresendo 7. RADIATION OR TRANSMI			
None			
None 8. OTHER SOUNDS (e.g., click) Mid Systolic Clic			
8. OTHER SOUNDS (e.g., click) Mid Systolic Clic	: k GRAM (Please attach results - NOT TRACI	NG5.)	
 8. OTHER SOUNDS (e.g., click) Mid Systolic Clic 9. RESULT OF ECHOCARDIO Mitral Valve Prol 	GRAM (Please attach results - NOT TRACI		
 B. OTHER SOUNDS (e.g., click) Mid Systolic Clic 9. RESULT OF ECHOCARDIO Mitral Valve Prol DOPPLER: No evid 	GRAM (Please attach results - NOI IRACH apse, minimal lence of mitral regurg		
 B. OTHER SOUNDS (e.g. click) Mid Systolic Clic 9. RESULT OF ECHOCARDIO Mitral Valve Prol DOPPLER: No evid 10. FINAL IMPRESSION AND 	GRAM (Please attach results - NOI IRACH apse, minimal lence of mitral regurg		
 B. OTHER SOUNDS (e.g. click) Mid Systolic Clic 9. RESULT OF ECHOCARDIO Mitral Valve Prol DOPPLER: No evid 10. FINAL IMPRESSION AND 	GRAM (Please attach results - NOI IRACH apse, minimal lence of mitral regurg OTHER COMMENTS by P.E. and by echo.		c. DATE SIGNED
 8. OTHER SOUNDS (e.g., click) Mid Systolic Clic 9. RESULT OF ECHOCARDIO Mitral Valve Prol DOPPLER: No evid 10. FINAL IMPRESSION AND Innocent murmur b 11. EXAMINING PHYSICIAN 	GRAM (Please attach results - NOI IRACH apse, minimal lence of mitral regurg OTHER COMMENTS by P.E. and by echo.	gitation	C. DATE SIGNED 7 May 87

	DOD MEDICAL EXAMIN HEART MU	RMUR EVALUATIÒ	N
	Priva	cy Act Statement	
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.		
PRINCIPAL PURPOSE:	To update a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University o Health Sciences (USUHS).		
ROUTINE USE:	•	to authorized personnel	the service academies, ROTC or USUHS. involved in the selection process. The ation.
DISCLOSURE:	Voluntary; however, failure process and hamper your car	•	information will impede the selection
. NAME OF APPLICANT (La	st, First, Middle Initial)		2. SSN OF APPLICANT
	INSTRUC	TIONS TO EXAMINER	
of "innocent" or "func	mitral valve prolapse and bicu	spid aortic valve are being t that you complete this for	found increasingly even in the presence m which will enable the Department of the applicant's cardiac status.
. GRADE, AMPLITUDE OR		4. LOCATION (Where is the s	
	RDIAC CYCLE (e.g., mid-systole) JND (e.g., crescendo-decrescendo)	I	
. CHARACTER OF THE SOL	JND (e.g., crescendo-decrescendo)		
6. CHARACTER OF THE SOL 7. RADIATION OR TRANSMI	JND (e.g., crescendo-decrescendo) ISSION OF THE SOUND		
6. CHARACTER OF THE SOL 7. RADIATION OR TRANSM 8. OTHER SOUNDS (e.g., click)	JND (e.g., crescendo-decrescendo) ISSION OF THE SOUND)	
5. CHARACTER OF THE SOL 7. RADIATION OR TRANSM 8. OTHER SOUNDS (e.g., click) 9. RESULT OF ECHOCARDIC	JND (e.g., crescendo-decrescendo) ISSION OF THE SOUND DGRAM (Please attach results - NOT TRACINGS.		
D. RESULT OF ECHOCARDIC	JND (e.g., crescendo-decrescendo) ISSION OF THE SOUND DGRAM (Please attach results - NOT TRACINGS.		
5. CHARACTER OF THE SOL 7. RADIATION OR TRANSM 8. OTHER SOUNDS (e.g., click)	JND (e.g., crescendo-decrescendo) ISSION OF THE SOUND DGRAM (Please attach results - NOT TRACINGS. D OTHER COMMENTS		
5. CHARACTER OF THE SOL 7. RADIATION OR TRANSM 8. OTHER SOUNDS (e.g., click) 9. RESULT OF ECHOCARDIC	JND (e.g., crescendo-decrescendo) ISSION OF THE SOUND DGRAM (Please attach results - NOT TRACINGS. D OTHER COMMENTS) SIGNATURE	c. DATE SIGNED

		DOD MED	MEDICAL EXAMINATIO	EXAMINATION REVIEW BOARD (DODMERB)	ODMERB) IES		
			Privacy Ac	Privacy Act Statement			
AUTHORITY:	Title 10, USC 133, 3012,		5031, 8012 and Executive Order 9397	er 9397.			
PRINCIPAL PURPOSE: 7	To update a medical Scholarship Programs,	medical file as par ograms, or the Unifo	t of the application prmed Services Unive	To update a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).	Service Academy, Re es (USUHS).	serve Officer Traini	ng Corps (ROTC)
ROUTINE USE: 7	To determine medical authorized personnel in	medical acceptabil rsonnel involved in t	ity for one or more the selection process	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.	emies, ROTC or USU umber (SSN) is used f	HS. Information wi or positive identifica	II be released to tion
DISCLOSURE:	Voluntary; ho	wever, failure to fur	nish the requested i	Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.	de the selection proce	iss and hamper your	candidacy.
1. NAME OF APPLICANT (Last, First, Middle Initial)	irst, Middle Initial)			2. SSN OF APPLICANT		3. DATE OF EXAMINATION	NOL
DOE, JOHN E				000-00-0001		7 May 87	
4. PRIOR TO EXERCISING, PROVIDE THE RESULTS OF A THEOPHYLLINE TEST	VIDE THE RESU	JLTS OF A BLOOD AMINOPHYLLINE/	IOPHYLLINE/	5. SPECIFIC REFERENCE	5. SPECIFIC REFERENCE TO THE STANDARD USED FOR NORMAL	D FOR NORMAL	
Theophylline level:	1: 0 ng/ml	-		Normal thera	therapeutic range 10-2	10-20 ng/m1	
6. VIGOROUS EXERCISE TO CONSIST OF 8 TO 10 MINUTES OF RUNNING. THIS EXERCISE MAY BE ACCOMPLISHED ON A TREADMILL. PERFORM THE FUNCTION TEST IMMEDIATELY UPON CESSATION OF THE EXERCISE. STATE DURATION OF EXERCISE	DNSIST OF 8 TO M THE FUNCTIO ATION OF EXER	10 MINUTES OF RUNNI N TEST IMMEDIATELY U CISE	ES OF RUNNING. THIS EXERCISE MA MEDIATELY UPON CESSATION OF	Y BE ACCOMPLISHED	<u>NOTE</u> : Administer th	Administer the bronchodilator 4 minutes after exercise and perform the function test one minute thereafter.	tes after exercise and thereafter.
			TEST	TEST RESULTS			
		a. BEFORE	a. BEFORE EXERCISE	b. AFTER	b. AFTER EXERCISE	C. AFTER BRONCHODILATOR	ICHODILATOR
		NORMAL (1)	va PREDICTED (2)	NORMAL (1)	% PREDICTED (2)	NORMAL (1)	% PREDICTED (2)
7. TOTAL VITAL CAPACITY		4.50	89%	4.30	85%	4.55	206
8. FEV-1.0		3.97	%76	3.73	89%	4.08	97%
9. MEFR 25 - 75 %		4.42	87%	3.99	78%	5.01	88%
10. WAS WHEEZING PRESENT		YES	QN	11. IS THE PATIENT TA	11. IS THE PATIENT TAKING ANY MEDICATIONS? (X one)	? (X one)	
a. BEFORE EXERCISE			X	a. YES (Specify medications and usage)	tions and usage)		
b. AFTER EXERCISE			X				
C AFTER BRONCHODILATOR			Х	XX B. NU	:		
12. EXAMINER							
TYPED OR PRINTED NAME (1-set, First, Middle Initial) Wally, Edward P	st, Middle Initial)			b. SIGNATURE	(0)		
Chief, Pulmonary Clinic, WBAMC,	Clinic, WB/	AMC, EP, TX		>	7		
DD Form 2375, MAY 85							

		DOD MED PUI	LMONARY FL	DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) PULMONARY FUNCTION STUDIES	ODMERB) IES		
AUTHORITY	Title 10 USC 1	Privacy Act State Title 10 11SC 133 3012 5031 8012 and Eventive Order 9397	Privacy Ac	Privacy Act Statement utive Order 9397			
PRINCIPAL PURPOSE:	To update a medical Scholarship Programs,		t of the applicatio ormed Services Unive	file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) or the Uniformed Services University of Health Sciences (USUHS).	Service Academy, Reve es (USUHS).	serve Officer Training	g Corps (ROTC)
ROUTINE USE:	To determine authorized per	medical acceptabil rsonnel involved in t	lity for one or more the selection process	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.	emies, ROTC or USUI umber (SSN) is used fo	45. Information will or positive identificati	be released to on.
DISCLOSURE:	Voluntary; however,	wever, failure to fur	nish the requested i	failure to furnish the requested information will impede the selection process and hamper your candidacy.	ie the selection proce	ss and hamper your c	andidacy.
1. NAME OF APPLICANT (Last, First, Middle Initial)	ist, First, Middle Initial)			2. SSN OF APPLICANT		3. DATE OF EXAMINATION	N
4. PRIOR TO EXERCISING, PROVIDE THE RESULTS OF THEOPHYLLINE TEST	PROVIDE THE RESU	JLTS OF A BLOOD AMINOPHYLLINE	40PHYLLINE/	5. SPECIFIC REFERENCE	5. SPECIFIC REFERENCE TO THE STANDARD USED FOR NORMAL	D FOR NORMAL	
6. VIGOROUS EXERCISE TO CONSIST OF 8 TO 10 MINUTES OF RUNNING. THIS EXERCISE MAY BE ACCOMPLISHED ON A TREADMILL. PERFORM THE FUNCTION TEST IMMEDIATELY UPON CESSATION OF THE EXERCISE. STATE DURATION OF EXERCISE	CONSIST OF 8 TO ORM THE FUNCTION URATION OF EXERC	VIGOROUS EXERCISE TO CONSIST OF 8 TO 10 MINUTES OF RUNNING. THIS EXERCISE ON A TREADMILL. PERFORM THE FUNCTION TEST IMMEDIATELY UPON CESSATION OF THE EXERCISE. STATE DURATION OF EXERCISE	ING. THIS EXERCISE MA IPON CESSATION OF	V BE ACCOMPLISHED	<u>NOTE</u> : Administer th	Administer the bronchodilator 4 minutes after exercise and perform the function test one minute thereafter.	s after exercise and ereafter.
			TEST	TEST RESULTS			
		a. BEFORE	a. BEFORE EXERCISE	b. AFTER	b. AFTER EXERCISE	C. AFTER BRONCHODILATOR	HODILATOR
		NORMAL (1)	% PREDICTED (2)	NORMAL (1)	% PREDICTED (2)	NORMAL (1)	Ve PREDICTED (2)
7. TOTAL VITAL CAPACITY							
8. FEV - 1.0							
9. MEFR 25 - 75 %							
10. WAS WHEEZING PRESENT	E	YES	ON	11. IS THE PATIENT TA	11. IS THE PATIENT TAKING ANY MEDICATIONS? (X one)	(X one)	
a. BEFORE EXERCISE				a. YES (Specify medications and usage)	tions and usage)		
b AFTER EXERCISE				2 2 2 2			
C. AFTER BRONCHODILATOR				OV. a			
12. EXAMINER	• Firme Maindaff, Later.N			L CONSTINC			
a. TYPED OK PRINIED NAME (LASC, FIST, MIGGRE INKIA)	it, First, Middle Initial)			b. SIGNATURE			
a. Difle							
DD Form 2375, MAY 85							

Figure 10-2. DD FORM 2375 Reverse, MAY 85

		DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) RED/GREEN COLOR VISION TEST				
Privacy Act Statement						
AUTHORITY: T	itle 10, USC 133, 3012, 5031, 8012 and Executive Order	9397.				
(C	o update a medical file as part of the application pr Officer Training Corps (ROTC) Scholarship Programs, Health Sciences (USUHS).	ocess to a US Service a or the Uniformed Serv	Academy, Reserve vices University of			
i ii	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.					
	· · ·					
1. NAME OF APPLICANT (Last, First, Middle Initial) 2. SOCIAL SECURITY NUMBER OF APPLICANT						
FRELIX, ROSS L.		900-00-0009				
3. "I certify that Applica		. CAN NOT				
distinguish and identi paper. (Do not readminis	fy objects that are bright RED and bright GREEN," i.e., iter standard color vision test.)	balls of yarn, colored ba	alls, construction			
4. EXAMINER						
a. TITLE OF EXAMINER Color Vision Spec:	ialist	\wedge	c. DATE SIGNED 7 May 87			
DD Form 2377, MAY 85	Illinnan I Cho	else.	······································			

Figure 11-1. DD FORM 2377, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) RED/GREEN COLOR VISION TEST

	DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) RED / GREEN COLOR VISION TEST				
	Privacy Act Statement				
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.				
PRINCIPAL PURPOSE:	To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).				
ROUTINE USES:	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.				
DISCLOSURE:	Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.				
I. NAME OF AFFLICANT (1. NAME OF APPLICANT (Last, First, Middle Initial) 2. SOCIAL SECURITY NUMBER OF APPLICANT				
3. "I certify that Appl	(X One) a. CAN b. CAN NOT				
distinguish and ide paper. (Do not readm	ntify objects that are bright RED and bright GREEN," i.e., balls of yarn, colored balls, construction				
4. EXAMINER					
a. TITLE OF EXAMINER	b. SIGNATURE OF EXAMINER C. DATE SIGNED				
DD Form 2377, MAY 85					

Figure 11-2. DD FORM 2375 Reverse, MAY 85

S	DOD MEDICAL EXAM	TORY REGARDING HEA	DACHES
	Pri	vacy Act Statement	
AUTHORITY:	Title 10, USC 133, 3012, 503	1, 8012 and Executive Order 9397.	
PRINCIPAL PURPOSE:	To update a medical file as Officer Training Corps (RO Health Sciences (USUHS).	s part of the application process to ITC) Scholarship Programs, or the U	a U.S. Service Academy, Reserve Jniformed Services University of
ROUTINE USE:	Information will be release	ptability for one or more of the ser ed to authorized personnel involve) is used for positive identification.	vice academies, ROTC or USUHS ed in the selection process. The
DISCLOSURE:	Voluntary; however, failur process and hamper your ca	re to furnish the requested inform andidacy.	nation will impede the selection
		INSTRUCTIONS	
	following information conce ded, please use reverse side o	rning your history of headaches. Be f this form.	e very specific in your answers. If
1. HOW OFTEN DO YOUR H Once a month.	IEADACHES OCCUR? (e.g., monthly, qu	arterly, every six months, etc.)	
2. WHEN HEADACHES OCCU Once a day.	JR, WHAT IS THEIR FREQUENCY?	(e.g., once a day, twice, three times, etc.)	· · · · · · · · · · · · · · · · · · ·
	DACHES USUALLY LAST? (e.g., 1 hou	ur, 2 hours, 6 hours, etc.)	
2 hours	DACHES USUALLY LAST? (e.g., 1 hou	ur, 2 hours, 6 hours, etc.)	
	DACHES USUALLY LAST? (e.g., 1 hou	ır, 2 hours, 6 hours, etc.)	
	DACHES USUALLY LAST? (e.g., 7 hou	ır, 2 hours, 6 hours, etc.)	
	DACHES USUALLY LAST? (e.g., 7 hou	ır, 2 hours, 6 hours, etc.)	
2 hours			
2 hours 4. Have you ever taken		adaches? IF SO, PLEASE EXPLAIN IN DE	TAIL (e.g., what medication, usual dose, etc.)
2 hours			TAIL (e.g., what medication, usual dose, etc.)
2 hours 4. Have you ever taken			TAIL (e.g., what medication, usual dose, etc.)
2 hours A. HAVE YOU EVER TAKEN			TAIL (e.g., what medication, usual dose, etc.)
2 hours A. HAVE YOU EVER TAKEN			TAIL (e.g., what medication, usual dose, etc.)
2 hours 4. Have you ever taken			TAIL (e.g., what medication, usual dose, etc.)
2 hours A. HAVE YOU EVER TAKEN Tylenol			TAIL (e.g., what medication, usual dose, etc.)
2 hours A. HAVE YOU EVER TAKEN Tylenol	ANY MEDICATIONS FOR YOUR HE		TAIL (e.g., what medication, usual dose, etc.)
2 hours A. HAVE YOU EVER TAKEN Tylenol 5. DO HEADACHES INTERFE	ANY MEDICATIONS FOR YOUR HE		TAIL (e.g., what medication, usual dose, etc.)
2 hours A. HAVE YOU EVER TAKEN Tylenol 5. DO HEADACHES INTERFE	ANY MEDICATIONS FOR YOUR HE		TAIL (e.g., what medication, usual dose, etc.)
2 hours 4. HAVE YOU EVER TAKEN Tylenol 5. DO HEADACHES INTERFE	ANY MEDICATIONS FOR YOUR HE		TAIL (e.g., what medication, usual dose, etc.)
2 hours 4. HAVE YOU EVER TAKEN Tylenol 5. DO HEADACHES INTERFE No	ANY MEDICATIONS FOR YOUR HE	ADACHES? IF SO, PLEASE EXPLAIN IN DE	TAIL (e.g., what medication, usual dose, etc.)
2 hours 4. HAVE YOU EVER TAKEN Tylenol 5. DO HEADACHES INTERFE No 5. LIST ANY OTHER PERTINE	ANY MEDICATIONS FOR YOUR HE	ADACHES? IF SO, PLEASE EXPLAIN IN DE	TAIL (e.g., what medication, usual dose, etc.)
2 hours A. HAVE YOU EVER TAKEN Tylenol 5. DO HEADACHES INTERFE No	ANY MEDICATIONS FOR YOUR HE	ADACHES? IF SO, PLEASE EXPLAIN IN DE	TAIL (e.g., what medication, usual dose, etc.)
2 hours 4. HAVE YOU EVER TAKEN Tylenol 5. DO HEADACHES INTERFE No 5. LIST ANY OTHER PERTINE	ANY MEDICATIONS FOR YOUR HE	ADACHES? IF SO, PLEASE EXPLAIN IN DE	TAIL (e.g., what medication, usual dose, etc.)
2 hours 4. HAVE YOU EVER TAKEN Tylenol 5. DO HEADACHES INTERFE No 5. LIST ANY OTHER PERTINE	ANY MEDICATIONS FOR YOUR HE	ADACHES? IF SO, PLEASE EXPLAIN IN DE	TAIL (e.g., what medication, usual dose, etc.)
2 hours 3. HAVE YOU EVER TAKEN Tylenol 5. DO HEADACHES INTERFE No 5. LIST ANY OTHER PERTINE	ANY MEDICATIONS FOR YOUR HE	ADACHES? IF SO, PLEASE EXPLAIN IN DE	TAIL (e.g., what medication, usual dose, etc.)
2 hours 3. HAVE YOU EVER TAKEN Tylenol 5. DO HEADACHES INTERFE NO 5. LIST ANY OTHER PERTINE N/A	ANY MEDICATIONS FOR YOUR HE RE WITH NORMAL ACTIVITIES?	ADACHES? IF SO, PLEASE EXPLAIN IN DE	TAIL (e.g., what medication, usual dose, etc.)
2 hours 3. HAVE YOU EVER TAKEN Tylenol 5. DO HEADACHES INTERFE NO 5. LIST ANY OTHER PERTINE N/A 7. HAS A PHYSICIAN DIAGN	ANY MEDICATIONS FOR YOUR HE RE WITH NORMAL ACTIVITIES?	ADACHES? IF SO, PLEASE EXPLAIN IN DE	TAIL (e.g., what medication, usual dose, etc.)
2 hours 3. HAVE YOU EVER TAKEN Tylenol 5. DO HEADACHES INTERFE NO 5. LIST ANY OTHER PERTINE N/A	ANY MEDICATIONS FOR YOUR HE RE WITH NORMAL ACTIVITIES?	ADACHES? IF SO, PLEASE EXPLAIN IN DE	TAIL (e.g., what medication, usual dose, etc.)
2 hours 3. HAVE YOU EVER TAKEN Tylenol 5. DO HEADACHES INTERFE NO 5. LIST ANY OTHER PERTINE N/A 7. HAS A PHYSICIAN DIAGN	ANY MEDICATIONS FOR YOUR HE RE WITH NORMAL ACTIVITIES?	ADACHES? IF SO, PLEASE EXPLAIN IN DE	TAIL (e.g., what medication, usual dose, etc.)
2 hours 4. HAVE YOU EVER TAKEN Tylenol 5. DO HEADACHES INTERFE NO 5. LIST ANY OTHER PERTINE N/A 7. HAS A PHYSICIAN DIAGN	ANY MEDICATIONS FOR YOUR HE RE WITH NORMAL ACTIVITIES?	ADACHES? IF SO, PLEASE EXPLAIN IN DE	TAIL (e.g., what medication, usual dose, etc.)
2 hours 3. HAVE YOU EVER TAKEN Tylenol 5. DO HEADACHES INTERFE NO 5. LIST ANY OTHER PERTINE N/A 7. HAS A PHYSICIAN DIAGN	ANY MEDICATIONS FOR YOUR HE RE WITH NORMAL ACTIVITIES?	ADACHES? IF SO, PLEASE EXPLAIN IN DE	TAIL (e.g., what medication, usual dose, etc.)
2 hours A. HAVE YOU EVER TAKEN Tylenol 5. DO HEADACHES INTERFE No 5. LIST ANY OTHER PERTINE N/A 7. HAS A PHYSICIAN DIAGN Tension headac	ANY MEDICATIONS FOR YOUR HE RE WITH NORMAL ACTIVITIES?	ADACHES? IF SO, PLEASE EXPLAIN IN DE	TAIL (e.g., what medication, usual dose, etc.)
2 hours A. HAVE YOU EVER TAKEN Tylenol 5. DO HEADACHES INTERFE No 5. LIST ANY OTHER PERTINE N/A 7. HAS A PHYSICIAN DIAGN Tension headac	ANY MEDICATIONS FOR YOUR HE RE WITH NORMAL ACTIVITIES?	ADACHES? IF SO, PLEASE EXPLAIN IN DE	•
2 hours 4. HAVE YOU EVER TAKEN Tylenol 5. DO HEADACHES INTERFE NO 5. LIST ANY OTHER PERTINE N/A 7. HAS A PHYSICIAN DIAGN	ANY MEDICATIONS FOR YOUR HE RE WITH NORMAL ACTIVITIES?	ADACHES? IF SO, PLEASE EXPLAIN IN DE	TAIL (e.g., what medication, usual dose, etc.)

Figure 12-1. DD FORM 2378, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING HEADACHES

S	DOD MEDICAL EXAMINATION I		HES
	Privacy Act S	Statement	
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 an	d Executive Order 9397.	
PRINCIPAL PURPOSE:	To update a medical file as part of the Officer Training Corps (ROTC) Schola Health Sciences (USUHS).		
ROUTINE USE:	To determine medical acceptability f Information will be released to auth social security number (SSN) is used for	norized personnel involved in t	cademies, ROTC or USUHS. the selection process. The
DISCLOSURE:	Voluntary; however, failure to furn process and hamper your candidacy.	ish the requested information	will impede the selection
	INSTRUC	TIONS	
Please provide the additional space is need	following information concerning you ded, please use reverse side of this form	r history of headaches. Be very 1.	specific in your answers. If
1. HOW OFTEN DO YOUR H	IEADACHES OCCUR? (e.g., monthly, quarterly, every six	months, etc.)	
2. WHEN HEADACHES OCCU	JR, WHAT IS THEIR FREQUENCY? (e.g., once a day.	twice, three times, etc.)	
3. HOW LONG DO THE HEA	ADACHES USUALLY LAST? (e.g., 1 hour, 2 hours, 6 hou	ırs, etc.)	
			,
4. HAVE YOU EVER TAKEN	ANY MEDICATIONS FOR YOUR HEADACHES?	IF SO, PLEASE EXPLAIN IN DETAIL (e.	g., what medication, usual dose, etc.)
	ndi A Marine na na selati M		
5 DO HEADACHES INTERFE	RE WITH NORMAL ACTIVITIES?		
			····
6. LIST ANY OTHER PERTIN	ENT INFORMATION CONCERNING THIS PROBLE	M	
	····		· · · · · · · · · · · · · · · · · · ·
7. HAS A PHYSICIAN DIAGN	IOSED YOUR HEADACHES? IF SO, WHAT WE	RE THE FINDINGS?	
8. APPLICANT			
a SIGNATURE		6 SOCIAL SECURITY NUMBER	C. DATE SIGNED
DD Form 2378, MAY 85			l

Figure 12-2. DD FORM 2378 Reverse, MAY 85

	Privacy Act	Statement
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 an	nd Executive Order 9397.
PRINCIPAL PURPOSE:		the application process to a US Service Academy, Reserve arship Programs, or the Uniformed Services University of
ROUTINE USES:	To determine medical acceptability f Information will be released to auti social security number (SSN) is used fo	for one or more of the service academies, ROTC or USUHS. horized personnel involved in the selection process. The pr positive identification.
DISCLOSURE:	Voluntary; however, failure to furn process and hamper your candidacy.	ish the requested information will impede the selection
1. NAME OF APPLICANT ((Last, First, Middle Initial)	2. SSN OF APPLICANT
BENNETT, TERRY	G.	001-11-1011
	INSTRUC	
needed, use the rever 3. HOW DID THE HEAD I Playing footbal	se side of this form. INJURY OCCUR?	ry. Be very specific in your answers. If additional space is
1. H OW OLD WERE YOU 15 years old	WHEN IT HAPPENED?	
 15 years old WERE YOU UNCONSCIO yes, 2 minutes DID YOU HAVE A SKUL 	DUS? HOW LONG?	
 15 years old 5. WERE YOU UNCONSCIO yes, 2 minutes 6. DID YOU HAVE A SKUL No 7. DID YOU HAVE ANY 	DUS? HOW LONG?	LE; HEADACHES, VOMITING, AMNESIA, DOUBLE VISION, DIZZINESS,
 15 years old WERE YOU UNCONSCIO yes, 2 minutes DID YOU HAVE A SKUL No DID YOU HAVE ANY 	DUS? HOW LONG? LL FRACTURE? SYMPTOMS AFTER THE INJURY, FOR EXAMP THE SYMPTOM(S) LAST?	LE; HEADACHES, VOMITING, AMNESIA, DOUBLE VISION, DIZZINESS,
 15 years old 5. WERE YOU UNCONSCIO yes, 2 minutes 6. DID YOU HAVE A SKUE No 7. DID YOU HAVE A SKUE ETC.? HOW LONG DID Dizziness for 5 	DUS? HOW LONG? LL FRACTURE? SYMPTOMS AFTER THE INJURY, FOR EXAMP THE SYMPTOM(S) LAST? minutes. AL PROCEDURES ACCOMPLISHED SUCH	LE; HEADACHES, VOMITING, AMNESIA, DOUBLE VISION, DIZZINESS, AS ELECTROENCEPHALOGRAM, BRAIN SCAN, BURR HOLES,
 15 years old WERE YOU UNCONSCIO yes, 2 minutes DID YOU HAVE A SKUE No DID YOU HAVE A SKUE ETC.? HOW LONG DID Dizziness for 5 WERE ANY ADDITIONA PNEUMOENCEPHALOGR 	DUS? HOW LONG? LL FRACTURE? SYMPTOMS AFTER THE INJURY, FOR EXAMP THE SYMPTOM(S) LAST? minutes. AL PROCEDURES ACCOMPLISHED SUCH	· · · · · · · · · · · · · · · · · · ·
 WERE YOU UNCONSCIO yes, 2 minutes DID YOU HAVE A SKUE No DID YOU HAVE A SKUE ETC.? HOW LONG DID Dizziness for 5 WERE ANY ADDITIONA PNEUMOENCEPHALOGR 	DUS? HOW LONG? LL FRACTURE? SYMPTOMS AFTER THE INJURY, FOR EXAMP THE SYMPTOM(S) LAST? minutes. AL PROCEDURES ACCOMPLISHED SUCH SAM, ETC.? ich were normal.	· · · · · · · · · · · · · · · · · · ·

INJURY

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING HEAD INJURY				
	Privacy Act Sta	tement		
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and E	xecutive Order 9397.		
PRINCIPAL PURPOSE:		application process to a US Service Academy, Reserve nip Programs, or the Uniformed Services University of		
ROUTINE USES:	To determine medical acceptability for Information will be released to author social security number (SSN) is used for p	one or more of the service academies, ROTC or USUHS. ized personnel involved in the selection process. The ositive identification.		
DISCLOSURE:	Voluntary; however, failure to furnish process and hamper your candidacy.	the requested information will impede the selection		
1. NAME OF APPLICANT (.ast, First, Middle Initial)	2. SSN OF APPLICANT		
		DNS Be very specific in your answers. If additional space is		
needed, use the revers 3. HOW DID THE HEAD II				
4. HOW OLD WERE YOU V	NHEN IT HAPPENED?			
S. WERE YOU UNCONSCIO	US? HOW LONG?			
6. DID YOU HAVE A SKUL	L FRACTURE?			
	SYMPTOMS AFTER THE INJURY, FOR EXAMPLE; THE SYMPTOM(S) LAST?	HEADACHES, VOMITING, AMNESIA, DOUBLE VISION, DIZZINESS,		
PNEUMOENCEPHALOGR	AL PROCEDURES ACCOMPLISHED SUCH AS AM, ETC.?	ELECTROENCEPHALOGRAM, BRAIN SCAN, BURR HOLES,		
9. SIGNATURE OF APPLIC	ANT	10. DATE SIGNED		
DD Form 2379, MAY 8	5	_		
	Figure 13-2. DD FORM	2379 Reverse, MAY 85		

	TATEMENT OF HISTORY REG	ARDING SLEEPWALKING
	Privacy Act Stat	lement
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and	
PRINCIPAL PURPOSE:	To update a medical file as part of the Officer Training Corps (ROTC) Scholars Health Sciences (USUHS).	e application process to a US Service Academy, Reserve ship Programs, or the Uniformed Services University o
ROUTINE USES:	To determine medical acceptability for Information will be released to autho social security number (SSN) is used for	r one or more of the service academies, ROTC or USUHS rized personnel involved in the selection process. The positive identification.
DISCLOSURE:	Voluntary; however, failure to furnish process and hamper your candidacy.	n the requested information will impede the selection
1. NAME OF APPLICANT (La	st, First, Middle Initial)	2. SSN OF APPLICANT
TIPTOE, JO	HNNY T.	100-01-1000
needed, use the reverse How FREQUENT ARE EP Twice a mont	ISODES OF SLEEPWALKING?	
*		
. WHEN DID YOU LAST SL April 1987, 17	.EEPWALK (month and year) (age)? years old	
April 1987, 17	years old RTINENT INFORMATION RELATED TO YOUR SLEEP	PWALKING. hto the living room. I wake up in
April 1987, 17 PROVIDE ANY OTHER PER I get up in the	years old RTINENT INFORMATION RELATED TO YOUR SLEEP	nto the living room. I wake up in
April 1987, 17 PROVIDE ANY OTHER PER I get up in the	years old RTINENT INFORMATION RELATED TO YOUR SLEEP middle of the night and walk in	nto the living room. I wake up in
April 1987, 17 PROVIDE ANY OTHER PER I get up in the	years old RTINENT INFORMATION RELATED TO YOUR SLEEP middle of the night and walk in	nto the living room. I wake up in
April 1987, 17 PROVIDE ANY OTHER PER I get up in the	years old RTINENT INFORMATION RELATED TO YOUR SLEEP middle of the night and walk in	nto the living room. I wake up in
April 1987, 17 PROVIDE ANY OTHER PER I get up in the	years old RTINENT INFORMATION RELATED TO YOUR SLEEP middle of the night and walk in	nto the living room. I wake up in
April 1987, 17 PROVIDE ANY OTHER PER I get up in the	years old RTINENT INFORMATION RELATED TO YOUR SLEEP middle of the night and walk in	nto the living room. I wake up in
April 1987, 17 PROVIDE ANY OTHER PER I get up in the	years old RTINENT INFORMATION RELATED TO YOUR SLEEP middle of the night and walk ir and don't remember how I got th	nto the living room. I wake up in

Figure 14-1. DD FORM 2380, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING SLEEPWALKING

·····				
DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING SLEEPWALKING				
	Privacy Act Statement			
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executive Ord			
PRINCIPAL PURPOSE:	To update a medical file as part of the application p Officer Training Corps (ROTC) Scholarship Programs, Health Sciences (USUHS).	or the Uniformed Services University of		
ROUTINE USES:	To determine medical acceptability for one or more o Information will be released to authorized personne social security number (SSN) is used for positive identi	l involved in the selection process. The		
DISCLOSURE:	Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.			
1. NAME OF APPLICANT (Las	it, First, Middle Initial)	2. SSN OF APPLICANT		
<u> </u>	INSTRUCTIONS			
Please answer the follow needed, use the reverse	wing questions regarding sleepwalking. Be very specifi	c in your answers. If additional space is		
3. HOW FREQUENT ARE EPI	SODES OF SLEEPWALKING?			
		······································		
•				
A (A)() PAL ALM LIATE	TRANSING STREET			
4. WHEN DID YOU LAST SLE	EPWALK (month and year) (age)?			
5. PROVIDE ANY OTHER PER	TINENT INFORMATION RELATED TO YOUR SLEEPWALKING.			
<u> </u>		······		
<u> </u>				
6. SIGNATURE OF APPLICAN	T	7. DATE SIGNED		
DD Form 2380, MAY 85				

Figure 14-2. DD FORM 2380 Reverse, MAY 85

. <u> </u>	Privacy Act Stat	ement
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Ex	ecutive Order 9397.
PRINCIPAL PURPOSE:		application process to a US Service Academy, Reserve ip Programs, or the Uniformed Services University of
ROUTINE USES:	To determine medical acceptability for o Information will be released to authoriz social security number (SSN) is used for po	one or more of the service academies, ROTC or USUHS. zed personnel involved in the selection process. The sitive identification.
DISCLOSURE:	Voluntary; however, failure to furnish process and hamper your candidacy.	the requested information will impede the selection
1. NAME OF APPLICANT (MELLS, FRED D.		2. SSN OF APPLICANT 100-00-0010
	INSTRUCTIO	
Please answer the foll needed, use the reverse	owing questions regarding motion sickness	. Be very specific in your answers. If additional space is
	NESS (SUCH AS, AIR, TRAIN, CAR, SEA, SWING, CAI	
Sea sickness	allo aben no, an, man, enn, ola, orang, ca	
4. WHAT AGE DID IT FIRS	T HAPPEN?	
4. WHAT AGE DID IT FIRS 14 years old	T HAPPEN?	
	T HAPPEN?	
14 years old		
14 years old 5. HOW SEVERE AND FRE	QUENT ARE EPISODES?	
14 years old 5. HOW SEVERE AND FRE	QUENT ARE EPISODES?	is happened only once.
14 years old 5. HOW SEVERE AND FRE		is happened only once.
14 years old 5. HOW SEVERE AND FRE	QUENT ARE EPISODES?	is happened only once.
14 years old 5. HOW SEVERE AND FRE	QUENT ARE EPISODES?	is happened only once.
14 years old	QUENT ARE EPISODES?	is happened only once.
14 years old 5. HOW SEVERE AND FRE	QUENT ARE EPISODES?	is happened only once.
14 years old 5. HOW SEVERE AND FRE	QUENT ARE EPISODES?	is happened only once.
14 years old 5. HOW SEVERE AND FRE I was sick all	QUENT ARE EPISODES? . day while deep sea fishing. Thi	
14 years old 5. HOW SEVERE AND FRE I was sick all 6. PROVIDE ANY OTHER F	QUENT ARE EPISODES? day while deep sea fishing. Thi PERTINENT INFORMATION RELATED TO YOUR MOT	ION SICKNESS.
14 years old 5. HOW SEVERE AND FRE I was sick all 6. PROVIDE ANY OTHER F	QUENT ARE EPISODES? day while deep sea fishing. Thi PERTINENT INFORMATION RELATED TO YOUR MOT	ION SICKNESS.
14 years old 5. HOW SEVERE AND FRE I was sick all 6. PROVIDE ANY OTHER F	QUENT ARE EPISODES? . day while deep sea fishing. Thi	ION SICKNESS.
14 years old 5. HOW SEVERE AND FRE I was sick all 6. PROVIDE ANY OTHER F	QUENT ARE EPISODES? day while deep sea fishing. Thi PERTINENT INFORMATION RELATED TO YOUR MOT	ION SICKNESS.
14 years old 5. HOW SEVERE AND FRE I was sick all 6. PROVIDE ANY OTHER F	QUENT ARE EPISODES? day while deep sea fishing. Thi PERTINENT INFORMATION RELATED TO YOUR MOT	ION SICKNESS.
14 years old 5. HOW SEVERE AND FRE I was sick all 6. PROVIDE ANY OTHER F	QUENT ARE EPISODES? day while deep sea fishing. Thi PERTINENT INFORMATION RELATED TO YOUR MOT	ION SICKNESS.
14 years old 5. HOW SEVERE AND FRE I was sick all 6. PROVIDE ANY OTHER F	QUENT ARE EPISODES? day while deep sea fishing. Thi PERTINENT INFORMATION RELATED TO YOUR MOT	ION SICKNESS.
14 years old 5. HOW SEVERE AND FRE I was sick all 6. PROVIDE ANY OTHER F	QUENT ARE EPISODES? day while deep sea fishing. Thi PERTINENT INFORMATION RELATED TO YOUR MOT	ION SICKNESS.
14 years old 5. HOW SEVERE AND FRE I was sick all 6. PROVIDE ANY OTHER F	QUENT ARE EPISODES? day while deep sea fishing. Thi PERTINENT INFORMATION RELATED TO YOUR MOT	ION SICKNESS.
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MOTION SICKNESS

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING MOTION SICKNESS				
	Privacy Act Statemen	<u> </u>		
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executiv	ve Order 9397.		
PRINCIPAL PURPOSE:		ation process to a US Service Academy, Reserve ograms, or the Uniformed Services University of		
ROUTINE USES:		more of the service academies, ROTC or USUHS. ersonnel involved in the selection process. The identification.		
DISCLOSURE:	process and hamper your candidacy.			
1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT		
	INSTRUCTIONS			
Please answer the foll needed, use the rever	owing questions regarding motion sickness. Be v	very specific in your answers. If additional space is		
	NESS (SUCH AS, AIR, TRAIN, CAR, SEA, SWING, CARNIVAL	RIDES, ETC.).		
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4. WHAT AGE DID IT FIRS	T HAPPEN?			
· · · · · · · · · · · · · · · · · · ·				
<u></u>				
5. HOW SEVERE AND FRE	QUENT ARE EPISODES?			
	,,	•		
D. PROVIDE ANY OTHER	PERTINENT INFORMATION RELATED TO YOUR MOTION SI	LKNESS.		
}				
7. SIGNATURE OF APPLIC		8. DATE SIGNED		
A SIGNATURE OF AFFER	·····			
DD Form 2381, MAY 8	3			

Figure 15-2. DD FORM 2381 Reverse, MAY 85

	Privacy Act Sta	itement			
AUTHORITY:	Title 10, US Code 133, 3012, 5031, 8012				
PRINCIPAL PURPOSE:	To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).				
ROUTINE USES:	To determine medical acceptability for one or more of the service academies, ROTC or USUHS Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.				
DISCLOSURE:	Voluntary; however, failure to furnish the requested information will impede the selectio process and hamper your candidacy.				
1. NAME OF APPLICANT (L	Last, First, Middle Initial)	2. SSN OF APPLICANT			
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3. NUMBER AND APPROX	space is needed, use the reverse side of th IMATE DATES OF ATTACKS OR EPISODES. May 85, 14 July 85, 1 October 85				
	D DURATION OF ATTACKS.				
4. SIGNS, SYMPTOMS AND Wheezing, shortn					
Wheezing, shortn		Π.			
Wheezing, shortn 5. Type and amount of	ness of breath.	п.			
Wheezing, shorth 5. TYPE AND AMOUNT OF Theodur 300 mgs,	Mess of breath. F MEDICATION USED AND LENGTH OF TREATMEN 3 times a day for 30 days.				
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Wheezing, shorth 5. TYPE AND AMOUNT OF Theodur 300 mgs, 6. TYPE OF AND DURATIO	Mess of breath. F MEDICATION USED AND LENGTH OF TREATMEN 3 times a day for 30 days.				
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 Wheezing, shorth S. TYPE AND AMOUNT OF Theodur 300 mgs, 6. TYPE OF AND DURATIO N/A 7. HAS MAINTENANCE DO Proventil as nee 8. AGE AT LAST ATTACK O 16 years old 9. IS THERE ANY HISTORY 	F MEDICATION USED AND LENGTH OF TREATMEN 3 times a day for 30 days. ON OF HYPOSENSITIZATION (DESENSITIZATION) (IF Dise BEEN ATTAINED? <	ANY) EMPLOYED, GIVING INCLUSIVE DATES.			

Figure 16-1. DD FORM 2382, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING HAY FEVER, SINUSITIS, ASTHMA AND/OR ALLERGIES

STATEMENT OF	DOD MEDICAL EXAMINATION RE HISTORY REGARDING HAY FEVI	ER, SINUSITIS, ASTHMA AND/OR ALLERGIES			
	Privacy Act St	atement			
AUTHORITY:	Title 10, US Code 133, 3012, 5031, 8012	and EO 9397, November 1943 (SSN).			
PRINCIPAL PURPOSE:		e application process to a US Service Academy, Reserve ship Programs, or the Uniformed Services University of			
ROUTINE USES:	Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.				
DISCLOSURE:	Voluntary; however, failure to furnis process and hamper your candidacy.	h the requested information will impede the selection			
1. NAME OF APPLICANT a	ast, First, Middle Initial)	2. SSN OF APPLICANT			
	INSTRUCTIO	 DNS			
		nusitis, asthma and/or allergies. Be very specific in your			
3. NUMBER AND APPROXI	MATE DATES OF ATTACKS OR EPISODES.				
4. SIGNS, SYMPTOMS AND	DURATION OF ATTACKS.				
	· · · · · · · · · · · · · · · · · · ·				
5. TYPE AND AMOUNT OF	MEDICATION USED AND LENGTH OF TREATMEN	17.			
6. TYPE OF AND DURATION	N OF HYPOSENSITIZATION (DESENSITIZATION) (IF	ANY) EMPLOYED, GIVING INCLUSIVE DATES.			
7. HAS MAINTENANCE DOS	E BEEN ATTAINED?				
8. AGE AT LAST ATTACK O	F ASTHMA AND DATE LAST ASTHMA MEDICAT	ON WAS USED.			
9. IS THERE ANY HISTORY	OF ALLERGIC SKIN DISORDER? IF YES, PLEASE E	XPLAIN.			
10.SIGNATURE OF APPLICA	NT				
IV. SIGNATURE OF APPLICA		.11.DATE SIGNED			
D Form 2382, MAY 87	Previous edition	n may be used			

	STATEMENT OF USE RE				
	Privacy Act	Statement			
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 ar	nd Executive Order 9397.			
PRINCIPAL PURPOSE:	To update a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).				
ROUTINE USE:	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The Social Security number (SSN) is used for positive identification.				
DISCLOSURE:	Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.				
1. NAME OF APPLICANT (La	ist, First, Middle Initial)		2. SSN OF APPLICANT		
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	INSTRUC				
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space is needed, use re		neureation. De very specifie in y			
3. TYPE OF MEDICATION					
Actifed					
			······································		
4. REASON FOR USAGE					
4. REASON FOR USAGE Allergies	···				
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MEDICATION

	DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF USE REGARDING MEDICATI	
	Privacy Act Statement	
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.	
PRINCIPAL PURPOSE:	To update a medical file as part of the application process to a U Officer Training Corps (ROTC) Scholarship Programs, or the Unif Health Sciences (USUHS).	
ROUTINE USE:	To determine medical acceptability for one or more of the service Information will be released to authorized personnel involved ir Social Security number (SSN) is used for positive identification.	
<u>DISCLOSURE</u> :	Voluntary; however, failure to furnish the requested informatic process and hamper your candidacy.	on will impede the selection
1. NAME OF APPLICANT (La	st, First, Middle Initial)	2. SSN OF APPLICANT
	INSTRUCTIONS	
Plassa answar the	following questions regarding use of medication. Be very specific in	a your antwork off additional
space is needed, use re		i your answers. It additional
3. TYPE OF MEDICATION		
4. REASON FOR USAGE		
4. KEASUN FUR USAGE		
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5. HOW LONG HAVE YOU	TAKEN THIS MEDICATION?	
	· · · · · · · · · · · · · · · · · · ·	
6. HAVE YOU TAKEN ANY	OTHER MEDICATION IN THE LAST 90 DAYS PRIOR TO PHYSICAL? (List type and reason	for usage)
		······································
7. SIGNATURE OF APPLICA	NT	8. DATE SIGNED
DD Form 2383, MAY 85		

Figure 17-2. DD FORM 2383 Reverse, MAY 85

				Priva	icy Act St	atement						
AUTHOR	<u> TY</u> :	Title	Title 10, USC 133, 3012, 5031, 8012 and EO 9397, November 1943 (SSN).									
<u>PRINCIPA</u>	L PURPO	Reser	pdate a medical file as part of the application process to a US Service Academy, rve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services ersity of Health Sciences (USUHS).									
ROUTINE	<u>USES</u> :	USUH	To determine medical acceptability for one or more of the USUHS. Information will be released to authorized personr process. The social security number (SSN) is used for positive is					rsonnel inv	onnel involved in the selection			
<u>DISCLOSI</u>	JRE:			wever, fai ss and ham			requeste	d informa	tion will	impede the		
NAME OF A	PPLICANT	(Last, First, Middle	Initial)					2. SSN OF	APPLICANT			
MOORE,	JOHN X.							000-0	00-0100			
				INSTRUC	TIONS TO	EXAMINE	RS					
Please	e read rev	verse side of	this form	before adr	ninistering	g this test.						
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(e.g., iv w	1	2	3	4	5	6	7	8	9	NUMBER OF ERRORS PER RUN		
1st RUN	G/R	w/w	G/W	G/R	R/G	W/R	w/w	G/W	R/R	3		
2nd RUN	G/R	W/G	G/W	G/G	R/G	W/R	W/W	R/W	R/R	ø		
3rd RUN	G/R	W/R	G/W	G/G	R/G	W/R	w/w	R/W	R/R	ø		
REMARKS (C			<u> </u>				L.	1	R/ R			
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REMARKS (d												
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REMARKS (C	iontinue on rev	rerse if necessary)			1			T 5. DATE SI				

FARNSWORTH LANTERN COLOR VISION TEST - INSTRUCTIONS

PREPARATION FOR TESTING

1. Give the test in a normally lighted room; screen from glare; exclude sunlight. Examinee should not face the source of room illumination.

2. Only one person should be tested at a time. (Others shall not be allowed to watch.)

3. Station examinee eight feet from lantern.

4. If examinee ordinarily wears contact lenses or glasses for distance, they should be worn. Color correcting lenses, if worn, <u>must be removed</u> prior to testing.

ADMINISTRATION AND SCORING

1. Instruct examinee, "The lights you will see in this lantern are either red, green, or white. They look like signal lights at a distance. Two lights are presented at a time - in any combination. Call out the colors as soon as you see them, naming first the color at the top and then the color at the bottom. Remember, only three colors - red, green, and white - and top first."

2. Turn knob at top of lantern to change lights; depress button in center of knob to expose lights. Maintain regular timing of about two seconds per light.

3. Expose the lights in random order starting with a RG or GR combination (Numbers 1 or 5), continuing until each of the nine combinations has been exposed.

4. If no errors are made on this first run of nine pairs of lights, examinee is passed.

5. If any errors are made on this first run, give \underline{two} more complete runs.

6. Average the errors of these last two runs. If an average of more than one error per run is made, examinee is failed. If an average of one, or less than one error per run is made, examinee is passed.

7. An error is considered the miscalling of one or both of a pair of lights; if an examinee changes his/her response before the next light is presented, record the second response only.

8. If an examinee says "yellow," "pink," etc., you should say, "There are only three colors - red, green, and white."

9. If an examinee takes a long time to respond, you should say, "As soon as you see the lights, call them."

REMARKS (Continued)

DD Form 2489, FEB 87

Figure 18-2. FARNSWORTH LANTERN COLOR VISION TEST - INSTRUCTIONS

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) FARNSWORTH LANTERN COLOR VISION TEST

-		FAR	NSWOR	TH LAI	NTERN O	COLOR	VISION	TEST		
				Priva	cy Act Sta	tement				
AUTHORITY:		Title 1	0, USC 133,	3012, 50	31, <mark>8</mark> 012 an	nd EO 9397	, Novembe	er. 1943 (SSN	i) .	
PRINCIPAL PL	<u>JRPOSE</u> :	Reserv	To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).							
ROUTINE USI	<u>ES</u> :	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.							ies, ROTC or the selection	
DISCLOSURE			itary; how ion process				requested	l informati	on will	impede the
1. NAME OF APPLI	CANT (Last, Fi	irst, Middle In	nitial)				-	2. SSN OF APPLICANT		
	by letters		this form b	efore adn	-	this test.	_	aminee for	each ru	n of the test
	1	2	3	4	5	6	7	8	9	NUMBER OF ERRORS PER RUN
1st RUN										
2nd RUN							[
3rd RUN									·····	
4. SIGNATURE OF E	XAMINER		<u></u>	<u></u>	·····			5. DATE SIG	NED	

DD Form 2489, FEB 87

Figure 18-3. FARNSWORTH LANTERN COLOR VISION TEST

FARNSWORTH LANTERN COLOR VISION TEST - INSTRUCTIONS

PREPARATION FOR TESTING

1. Give the test in a normally lighted room; screen from glare; exclude sunlight. Examinee should not face the source of room illumination.

2. Only one person should be tested at a time. (Others shall not be allowed to watch.)

3. Station examinee eight feet from lantern.

4. If examinee ordinarily wears contact lenses or glasses for distance, they should be worn. Color correcting lenses, if worn, <u>must be removed</u> prior to testing.

ADMINISTRATION AND SCORING

1. Instruct examinee, "The lights you will see in this lantern are either red, green, or white. They look like signal lights at a distance. Two lights are presented at a time - in any combination. Call out the colors as soon as you see them, naming first the color at the top and then the color at the bottom. Remember, only three colors - red, green, and white - and top first."

2. Turn knob at top of lantern to change lights; depress button in center of knob to expose lights. Maintain regular timing of about two seconds per light.

3. Expose the lights in random order starting with a RG or GR combination (Numbers 1 or 5), continuing until each of the nine combinations has been exposed.

4. If no errors are made on this first run of nine pairs of lights, examinee is passed.

5. If any errors are made on this first run, give \underline{two} more complete runs.

6. Average the errors of these last two runs. If an average of more than one error per run is made, examinee is failed. If an average of one, or less than one error per run is made, examinee is passed.

7. An error is considered the miscalling of one or both of a pair of lights; if an examinee changes his/her response before the next light is presented, record the second response only.

8. If an examinee says "yellow," "pink," etc., you should say, "There are only three colors - red, green, and white."

9. If an examinee takes a long time to respond, you should say, "As soon as you see the lights, call them."

REMARKS (Continued)

DD Form 2489, FEB 87

Figure 18-4. FARNSWORTH LANTERN COLOR VISION TEST - INSTRUCTIONS

ADDITIONAL INSTRUCTIONS FOR PERFORMING MEDI-CAL TESTS

This attachment gives guidelines on the additional medical information needed along with the physical examination of applicants to the US service academy (Air Force, Military, Naval, Coast Guard, Merchant Marine), Four–Year ROTC Scholarship, or the USUHS.

a. Reading Aloud Test (RAT). Administer the RAT to all applicants. The test must be given as follows:

(1) Have the examinee stand erect, face the examiner across the room, and read aloud the statement in 2 below, as if he or she were confronting a class of students.

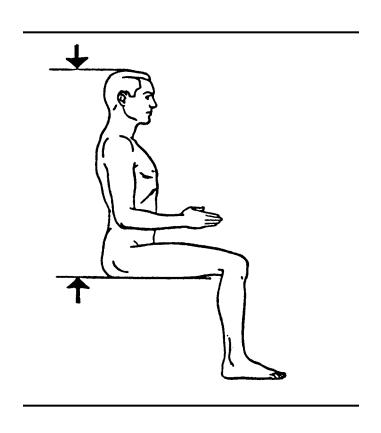
(2) If he or she pauses, even momentarily on any phrase or word, the examiner immediately and sharply says, 'what's that?' and makes the examinee start over again with the first sentence of the text. The true stammerer usually will halt again at the same word or phonetic combination, and will often show serious stammering.

"You wish to know all about my grandfather.Well, he is nearly 93 years old; he dresses himself in an ancient black frock coat, usually minus several buttons; yet, he still thinks as swiftly as ever. A long flowing beard clings to his chin giving those who observe him a pronounced feeling of the utmost respect. When he speaks, his voice is just a bit cracked and quivers a trifle. Twice each day he plays skillfully and with zest upon our small organ. Except in winter, when the ooze of snow or ice is present, he slowly takes a short walk each dat. We have often urged him to walk more and smoke less, but he always answers, "Banana oil!" Grandfather likes to be modern in his language."

b. Sitting Height. To measure sitting height, have the examinee sit on a hard surface, hips flexed at 90 degrees (o), lower legs dangling free, and torso erect, with head facing directly forward. Measure from the top of the head to the top of the hard surface the

examinee is seated upon. Measure sitting height to the nearest quarter of an inch. (See diagram.)

Figure 19-1A. ADDITIONAL INSTRUCTIONS FOR PERFORMING MEDICAL TESTS



c. Near Point of Accommodation. Have the examinee wear his or her usual corrective lenses. The object of the test is to determine the nearest point where the examinee can read print that is 1 millimeter (mm) (.62 Snellen–Metric), or J-2) high. Hold the test card so near the eye that the examinee cannot read it, then slowly move it away until the examinee can read the print correctly. Record the results for each eye in diopters. If an ophthalmologist or optometrist is doing the test, with the manifest refraction findings in place, use monocular push–up amplitude of accommodation and record the results for each eye in diopters.

d. Near Point of Convergence (NPC). The object of the test is determining the point on a ruler where eye convergence is the greatest. Place the ruler's zero mark about 15 mm from the corneal surface. Start the movable object at the far end of the ruler, and move it slowly toward the nose. The point of convergence is the point on the ruler where eye convergence is the greatest, but without breaking fusion. Record the results in millimeters.

e. Red Lens Test. The examinee should be 30 inches from a tangent screen or a central fixation point. The fixation point should be on a plain wall, 48 inches from the floor, with intersecting lines of 450, 900, 1350, and 1800, running at least 20 inches from the point of fixation. These lines may be marked at 4–inch intervals, and a cord 30 inches long fastened at the fixation point to measure the testing distance. The examinee's eye should be on an exact line, perpendicular to the fixation point so that the head and eyes are not tilted in any direction. Seat the examinee on an adjustable stool and steady his or her head by placing the chin on a chin rest, so that the visual axis will not change during the test. Put a red lens in front of one of the examinee's eyes. Then move a point of light outward in the six cardinal directions from the center of the screen; right, left, up and to the right, up and to the left, down and to the right, and down and to the left. Instruct the examinee to follow the light with his or her head, and to tell you if there is either a change in the color of the light (suppression) or a doubling of the light (diplopia). Demonstrate a change in the color of the light at the beginning of the test, showing that it may be either red, white, or pink, by using an occluder. Move the light into one of the upper diagonal fields until the brow cuts off the view from one, to verify that the examinee understands. The examinee should report a change in color. Place a five diopter prism, base up or base down, before one eye to produce diplopia, which the examinee should report. This will avoid the danger of routine negative responses. If you wish, alternate this prism with a plano lens of the same size to confuse the examinee. Note and record the point on the screen if the examinee has diplopia or suppression when no prism is being used.

Figure 19-1B. ADDITIONAL INSTRUCTIONS FOR PERFORMING MEDICAL TESTS

54

Glossary

Section I Abbreviations

ANSI American National Standard Institute

ASA American Standards Association

BAT Blood Alcohol Test

cm —Centimeters

CSP College Scholarship Program

CT Cover Test

o Degree

DOD Department of Defense

DODMERB Department of Defense, Medical Examination Review Board

DPA-V Depth Perception Apparatus —Verhoeff

ECG Electrocardiographic

EKG Electrocardiogram

FALANT Farnsworth Lantern

GU Genitourinary System

HIV Human Immune Virus

Hz Hertz

ISO International Standards Organization

mm Millimeters

MTF Medical Treatment Facility

NCNS No Complications, No Sequelae

NE Not Examined

NPC Near Point of Convergency

NS Nonsymptomatic

OTC Over the Counter

PA Physician Assistant

PAS Privacy Act Statement

PC Point of Convergence

PCNP Primary Care Nurse Practitioner

POC Professional Officer Course

RAT Reading Aloud Test

RBC Red Blood Cell

ROTC Reserve Officer Training Corps

SSN Social Security Number

UDS Urine Drug Screen

USUSH Uniformed Services University of the Health Sciences

VTA-ND Vision Test Apparatus — Near and Distant

VTS-CV Vision Test Set — Color Vision

WBC White Blood Cell

WHNS Well Healed, No Sequelae

Section II Terms This section contains no entries.

Section III Special Abbreviations and Terms This section contains no entries.

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