

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 5a and 9b);
- 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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\*AFR 160-13  
\*NAVMEDCOMINST 6120.2A  
\*CGCOMDTINST M6120.8B  
Effective 20 October 1989

### 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)

BY ORDER OF THE SECRETARIES OF THE AIR FORCE, THE ARMY, THE NAVY, AND DEPARTMENT OF TRANSPORTATION

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**History.** This publication has been reorganized to make it compatible with the Army electronic publishing database. No content has been changed.

**Summary.** This regulation give a uniform procedure for carrying out medical examinations of applicants for US service academies, Reserve Officer Training Corps (ROTC) Scholarship Programs and the Uniformed Services University of the Health Sciences (USUHS).

**Applicability.** This applies to all medical facility personnel who perform such medical

examinations, including the Air National Guard and US Air Force Reserve Units.

**Proponent and exception authority.**  
Not applicable.

**Army management control process.**  
Not applicable.

**Supplementation.** This regulation is affected 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

Records. For a list of abbreviations shown in this publication, see attachment 1.

**Suggested Improvements.** Not applicable.

**Distribution.** Distribution:

Air Force: F

Army: Active Army, ARNG, USAR: To be distributed in accordance with the requirements on DA Form 12-09-E, block number 3434, intended for command level B.

Navy: Ships and Stations Having Medical Department Personnel.

(Stocked: CO, VAVPUBFORMCEN, 5801 Tabor Ave., Phila., PA 19120-5099)

Coast Guard: To be distributed by Commandant (G-TIS) pursuant to COMDTNOTE 5600

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

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## 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 DODMERB. 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 9a, and signs it. The examining physician completes DD Form 2351 (attachment 2), and DD Form 2492 (attachment 3) according to paragraph 9b. 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 DODMERB. 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 5c. 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. Do 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 has 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:

1. 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, and 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 (attachment 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 (attachment 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) Farnsworth 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.

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL EXAMINATION <small>(This form is affected by the Privacy Act of 1974 - See DD Form 2005)</small>							1. DATE OF EXAMINATION 30 Sep 85		
<b>APPLICANT DATA</b>									
2. NAME (Last, First, Middle) JONES, HARRY WILLIAM, JR.			3. SOCIAL SECURITY NO. 111-22-3333		4a. DATE OF BIRTH 29 Jun 67	b. AGE 18	5. SEX MALE	6. RACE (Ethnic Group) CAUCASIAN	
7. HOME ADDRESS (Street, City, State and Zip Code) 1234 Main Street Colorado Springs CO 80918-2228				8. MILITARY STATUS (X One) a. ACTIVE DUTY <input checked="" type="checkbox"/> X b. CIVILIAN <input type="checkbox"/> c. RESERVE/GUARD <input type="checkbox"/>		9. EXAMINER ADDRESS (Street, City, State and Zip Code) USAFA Clinic/SGP USAF Academy Colorado Springs CO 80840-5000			
<b>MEASUREMENTS</b>									
10. HEIGHT a. STANDING 72 b. SITTING 37½		11. BLOOD PRESSURE 118/72		12. EKG <input checked="" type="checkbox"/> X a. NORMAL <input type="checkbox"/> b. ABNORMAL		13. AUDIOMETER 500 1000 2000 3000 4000 6000 RIGHT 5 5 5 10 5 10 LEFT 5 5 5 5 0 10			14. READING ALOUD TEST <input checked="" type="checkbox"/> a. SATISFACTORY <input type="checkbox"/> b. UNSATISFACTORY (Explain in Item 57)
16. WEIGHT 200		15. PULSE 7		18. REFRACTION a. CYCLO <input checked="" type="checkbox"/> X b. MANIFEST c. LENS		19. NEAR VISION a. 20/ 20 b. CORR TO 20/ c. BY d. 20/ 25 e. CORR TO 20/ 20 f. BY SAME			
17. DISTANT VISION a. RIGHT 20/ 25 b. CORR TO 20/ 20 c. LEFT 20/ 25 d. CORR TO 20/ 20		(1) SPH -0.25 (2) CYL +0.25 (3) AXIS 100 (4) SPH -0.25 (5) CYL +0.25 (6) AXIS 090		20. METROPHORIA (Far only) a. ES* 5 b. EX* 0 c. R.H. 1 d. L.H. 0		21. COVER TEST <input checked="" type="checkbox"/> X a. PASS b. FAIL		22. COLOR VISION a. TEST USED (1) VTS-CV No. Passed No. Failed X (2) FALANT 9/9 (3) OTHER (Specify)	
24. PC 70mm		25. ACCOMMODATION a. RIGHT 8.0 b. LEFT 8.8		23. DEPTH PERCEPTION a. TEST USED X (1) VTA-ND PASSES (1) F (2) DPA-V (2) (3) TITMUS/STEREO FLY (3)		26. RED LENS TEST <input checked="" type="checkbox"/> X a. PASS b. FAIL			
<b>LABORATORY</b>									
27. URINALYSIS a. PROTEIN NEG X T 1+ 2+ 3+ 4+ b. SUGAR X NEG T 1+ 2+ 3+ 4+ c. MICROSCOPIC EXAMINATION (X One) X (1) NEGATIVE (2) POSITIVE (List results)				28. BLOOD a. TYPE 0 c. HEMATOCRIT 48 b. RH FACTOR + d. HEMOGLOBIN 16.8			29. OTHER TESTS (Specify type and results)		
<b>CLINICAL EVALUATION</b>									
30. HEAD, FACE, NECK AND SCALP			57. NOTES (Describe every abnormality in detail. Enter the item number before each comment. Continue on reverse if necessary.)						
31. NOSE			34. 4cm post auricular surgical scar, left, WHNS.						
32. SINUSES			46. Moderate dextrosciosis, asymptomatic.						
33. MOUTH AND THROAT			50. 1cm vertical scar, dorsum left forearm, WHNS.						
34. EARS - GENERAL (Internal and external canals) (Auditory acuity under item 13)			52. Large left varicocele, asymptomatic.						
35. DRUMS (Perforation)			56. Recommend for service academies and ROTC programs.						
36. VALSALVA			58. EXAMINER						
37. EYES-GENERAL (Visual acuity and refraction under items 17, 18, and 19)			a. TYPED OR PRINTED NAME WILLIAM P. COX			b. SIGNATURE <i>William P. Cox</i>			
38. PUPILS (Equality and reaction)			c. RANK TSGT			d. CORPS OR DEGREE 90270C			
39. OCULAR MOTILITY (Associated parallel movements, nystagmus)			59. PHYSICIAN						
40. OPHTHALMOSCOPIC			a. TYPED OR PRINTED NAME LARRY D. JONES			b. RANK COL			
41. LUNGS AND CHEST (Include breasts)			c. DEGREE MD			d. SIGNATURE <i>Larry D. Jones</i>			
42. HEART (Thrust, size, rhythm, and sounds)									
43. VASCULAR SYSTEM (Varicosities, etc.)									
44. ABDOMEN AND VISCERA (Include hernia)									
45. ENDOCRINE SYSTEM									
46. SPINE, OTHER MUSCULOSKELETAL									
47. UPPER EXTREMITIES (Strength, range of motion)									
48. LOWER EXTREMITIES (Except feet) (Strength, range of motion)									
49. FEET									
50. IDENTIFYING BODY MARKS, SCARS, TATTOOS									
51. SKIN, LYMPHATICS									
52. G-U SYSTEM									
53. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate if indicated)									
54. PELVIC EXAMINATION									
55. NEUROLOGIC									
56. PSYCHIATRIC (Specify any personality deviation)									

DD Form 2351, SEP 85

DD Exception to SF 88 Approved by GSA/OIRM 7-85

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



<b>DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL EXAMINATION</b> <i>(This form is affected by the Privacy Act of 1974 - See DD Form 2005)</i>							1. DATE OF EXAMINATION				
<b>APPLICANT DATA</b>											
2. NAME (Last, First, Middle)			3. SOCIAL SECURITY NO.		4a. DATE OF BIRTH	b. AGE	5. SEX	6. RACE (Ethnic Group)			
7. HOME ADDRESS (Street, City, State and Zip Code)				8. MILITARY STATUS (X One)		9. EXAMINER ADDRESS (Street, City, State and Zip Code)					
				a. ACTIVE DUTY							
				b. CIVILIAN							
				c. RESERVE/GUARD							
<b>MEASUREMENTS</b>											
10. HEIGHT		11. BLOOD PRESSURE		12. EKG		13. AUDIOMETER		14. READING ALOUD TEST			
a. STANDING	b. SITTING			a. NORMAL	500	1000	2000	3000	4000	6000	a. SATISFACTORY
		15. PULSE		b. ABNORMAL	RIGHT						b. UNSATISFACTORY <i>(Explain in Item 57)</i>
16. WEIGHT					LEFT						
17. DISTANT VISION			18. REFRACTION		19. NEAR VISION						
a. RIGHT 20/	b. CORR TO 20/		(1) SPH	(2) CYL	(3) AXIS	a. 20/	b. CORR TO 20/	c. BY			
c. LEFT 20/	d. CORR TO 20/		(4) SPH	(5) CYL	(6) AXIS	d. 20/	e. CORR TO 20/	f. BY			
20. HETEROPIORIA (Far only)		21. COVER TEST		22. COLOR VISION		23. DEPTH PERCEPTION					
a. ES°	b. EX°	c. R.H.	d. L.H.	a. TEST USED	b. RESULTS	a. TEST USED	b. SCORE				
				a. PASS	(1) VTS-CV	No. Passed	No. Failed				
				b. FAIL	(2) FALANT						
					(3) OTHER (Specify)	(1) VTA-ND	(1)				
						(2) DPA-V	(2)				
						(3) TITMUS/STEREO FLY	(3)				
24. PC		25. ACCOMMODATION		26. RED LENS TEST							
		a. RIGHT	b. LEFT	a. PASS	b. FAIL						
<b>LABORATORY</b>											
27. URINALYSIS				28. BLOOD		29. OTHER TESTS (Specify type and results)					
a. PROTEIN	NEG	T	1+	2+	3+	4+	a. TYPE				
b. SUGAR	NEG	T	1+	2+	3+	4+	c. HEMATOCRIT				
c. MICROSCOPIC EXAMINATION (X One)	(1) NEGATIVE	(2) POSITIVE (List results)					d. HEMOGLOBIN				
<b>CLINICAL EVALUATION</b>											
NOR- MAL	X each item in the appropriate column <i>(Enter "NE" if not evaluated)</i>					ABNOR- MAL	57. NOTES (Describe every abnormality in detail. Enter the item number before each comment. Continue on reverse if necessary.)				
	30. HEAD, FACE, NECK AND SCALP										
	31. NOSE										
	32. SINUSES										
	33. MOUTH AND THROAT										
	34. EARS - GENERAL <i>(Internal and external canals)</i> <i>(Auditory acuity under item 13)</i>										
	35. DRUMS <i>(Perforation)</i>										
	36. VALSALVA										
	37. EYES-GENERAL <i>(Visual acuity and refraction)</i> <i>(under items 17, 18, and 19)</i>										
	38. PUPILS <i>(Equality and reaction)</i>										
	39. OCULAR MOTILITY <i>(Associated parallel move-)</i> <i>(ments, nystagmus)</i>										
	40. OPHTHALMOSCOPIC										
	41. LUNGS AND CHEST <i>(include breasts)</i>										
	42. HEART <i>(Thrust, size, rhythm, and sounds)</i>										
	43. VASCULAR SYSTEM <i>(Varicosities, etc.)</i>										
	44. ABDOMEN AND VISCERA <i>(include hernia)</i>										
	45. ENDOCRINE SYSTEM										
	46. SPINE, OTHER MUSCULOSKELETAL										
	47. UPPER EXTREMITIES <i>(Strength, range of motion)</i>										
	48. LOWER EXTREMITIES <i>(Except feet)</i> <i>(Strength,</i> <i>range of motion)</i>										
	49. FEET										
	50. IDENTIFYING BODY MARKS, SCARS, TATTOOS										
	51. SKIN, LYMPHATICS										
	52. G-U SYSTEM										
	53. ANUS AND RECTUM <i>(Hemorrhoids, fistulae)</i> <i>(prostate if indicated)</i>										
	54. PELVIC EXAMINATION										
	55. NEUROLOGIC										
	56. PSYCHIATRIC <i>(Specify any personality deviation)</i>										
	58. EXAMINER										
	a. TYPED OR PRINTED NAME			b. SIGNATURE							
	c. RANK	d. CORPS OR DEGREE									
	59. PHYSICIAN										
	a. TYPED OR PRINTED NAME	b. RANK	c. DEGREE	d. SIGNATURE							

DD Form 2351, SEP 85

DoD Exception to SF 88 Approved by GSA/OIRM 7-85

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

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

<b>Explanation</b>	<b>Model Entry</b>
<b>Item 1—Date of Examination.</b> Record dates in military style.	14 January 1985 21 Mar 85
<b>Item 2—Last Name, First Name, Middle Name.</b> Record the Entire middle name.	Jones, Harry William, Jr. Martinez, Catherine, Lucinda
<b>Item 3—Social Security Number.</b>	111-22-3333 001-01-1001
<b>Item 4a—Date of Birth.</b> Record date in military style.	15 Feb 68 29 Apr 67
<b>Item 4b—Age.</b>	17 18
<b>Item 5—Sex.</b> Do not abbreviate	Male Female
<b>Item 6—Race (Ethnic Group).</b> Do not abbreviate. Do not confuse with religion.	Caucasian, Black, Oriental, Indian (American), Puerto Rican, Mexican-American
<b>Item 7—Home Address.</b> Enter the address and nine-digit ZIP Code where the examinee receives mail.	1234 Main St. Colorado Springs CO 80840-6518
<b>Item 8—Military Status.</b> Check the block designating the applicant's current status.	
<b>Item 9—Examiner Address.</b> Complete name and address of agency doing examination	USAF School of Aerospace Medicine Brooks AFB TX 7823-5000
<b>Item 10—Height.</b> 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
<b>Item 11—Blood Pressure.</b> Record the sitting blood pressure.	120/84
<b>Item 12—Electrocardiogram (EKG).</b> Give every examinee a 12-lead EKG. The examinee does not have to be fasting. Check normal or abnormal, and submit actual tracings.	
<b>Item 13—Audiometer.</b> Give an audiometer test, include frequencies 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.	
<b>Item 14—Reading Aloud Test (RAT).</b> 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.	
<b>Item 15—Pulse.</b> Record the resting pulse in beats per minute.	72
<b>Item 16—Weight.</b> Measure weight in pounds, the nearest	150

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

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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 successfully 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.

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

**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.

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

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."

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

**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.

Es° Ex° R.H. L.H.  
8 0 1 0

**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

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

“pass.”

**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.

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

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

35mm

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

Right 10.0, Left 9.5

**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.

Diplopia in left lateral gaze,  
10 inches, from primary

**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.

2 RBC  
3 WBC

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

Type A  
Rh factor-Pos

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

Hematocrit 44  
Hemoglobin 16.5

**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).

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

**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. 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 murmur)

b. Late soft systolic “click” heard over

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

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, Sacroiliac, 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. 5x5cm 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.

One small external hemorrhoid,  
asymptomatic

**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

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<b>DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL HISTORY</b> <small>(This information is for official and medically confidential use only and will not be released to unauthorized persons.) (This form is subject to the Privacy Act of 1974. See DD Form 2005.)</small>		<small>Form Approved OMB No. 0704-0269 Expires Sep 30, 1989</small>																																																																																																																																																																																																																																																																																																																																													
<b>NAME</b> (Last, First, Middle Initial) MORAY, HARRY G.		<b>SOCIAL SECURITY NUMBER</b> 011-11-0001																																																																																																																																																																																																																																																																																																																																													
<b>PURPOSE OF EXAMINATION</b> DODMERB		<b>TELEPHONE NO.</b> (Include area code) (102) 962-0001																																																																																																																																																																																																																																																																																																																																													
<b>EXAMINATION FACILITY OR EXAMINER AND ADDRESS</b> (Include Zip Code) USAF Clinic Hanscom, Hanscom Fld MA 01101		<b>DATE OF EXAMINATION</b> 5 May 87																																																																																																																																																																																																																																																																																																																																													
<b>SECTION I - Mark applicable boxes in items 1 through 10</b>																																																																																																																																																																																																																																																																																																																																															
<b>1. How would you rate your present health?</b> <input checked="" type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		<b>6. If you smoke cigarettes how many do you smoke each day?</b> <input checked="" type="checkbox"/> Less than 1 pack <input type="checkbox"/> 1 pack <input type="checkbox"/> 1-1/2 packs <input type="checkbox"/> 2 packs or more																																																																																																																																																																																																																																																																																																																																													
<b>2. How many hours sleep do you usually get at night?</b> 4 or less <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input checked="" type="checkbox"/> 8 <input type="checkbox"/> 9 or more		<b>7. On the average, how many times per week do you drink any alcoholic beverages such as beer, wine, or liquor?</b> <input checked="" type="checkbox"/> Never (skip to Item 9) <input type="checkbox"/> Less than once <input type="checkbox"/> Once or twice <input type="checkbox"/> Three or four <input type="checkbox"/> Five or more																																																																																																																																																																																																																																																																																																																																													
<b>3. How many days per week do you exercise vigorously (enough to produce a sweat) for at least fifteen minutes?</b> None <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input checked="" type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		<b>8. When you drink, how many alcoholic drinks do you have (on the average)?</b> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 or more																																																																																																																																																																																																																																																																																																																																													
<b>4. Are you on any special diet?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<b>9. Have you ever used any of the following?</b> N/A Amphetamines   Barbiturates   Chemical inhalants Cocaine   Hallucinogens   Narcotic drugs																																																																																																																																																																																																																																																																																																																																													
<b>5. Indicate the tobacco products you currently use.</b> <input checked="" type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Snuff (Smokeless tobacco) <input type="checkbox"/> Pipes <input type="checkbox"/> None (Skip to Item 7)		<b>10. What is your marital status?</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed																																																																																																																																																																																																																																																																																																																																													
<b>SECTION II - Mark each item (11 through 94) "Yes" or "No." If you do not know the answer for a particular item, leave it blank. Every item marked "Yes" must be explained in the REMARKS section on the reverse.</b>																																																																																																																																																																																																																																																																																																																																															
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28 Periods of unconsciousness		<input checked="" type="checkbox"/>	54. Hemorrhoids or rectal disease		<input checked="" type="checkbox"/>	83. Learning disabilities or speech problems		<input checked="" type="checkbox"/>																																																																																																																																																																																																																																																																																																																																							
29 Head injury or skull fracture		<input checked="" type="checkbox"/>	55. Black or bloody stools		<input checked="" type="checkbox"/>	<b>D. FEMALES ONLY - Have you ever</b> N/A																																																																																																																																																																																																																																																																																																																																									
30 Epilepsy, seizures, or convulsions		<input checked="" type="checkbox"/>	56. Frequent or painful urination		<input checked="" type="checkbox"/>	84. Been treated for a female disorder, painful periods, or cramps																																																																																																																																																																																																																																																																																																																																									
31 Loss of memory or amnesia		<input checked="" type="checkbox"/>	57. Bed wetting since age 12		<input checked="" type="checkbox"/>	85. Had a change in menstrual pattern																																																																																																																																																																																																																																																																																																																																									
32 Depression, excessive worry or nervousness, anxiety		<input checked="" type="checkbox"/>	58. Blood, protein, or sugar in urine		<input checked="" type="checkbox"/>	86. Been pregnant or are you now pregnant																																																																																																																																																																																																																																																																																																																																									
33 Any mental condition or illness		<input checked="" type="checkbox"/>	59. Kidney stone		<input checked="" type="checkbox"/>	87. Taken birth control pills (If yes, give dates and product names)																																																																																																																																																																																																																																																																																																																																									
34 Frequent trouble sleeping		<input checked="" type="checkbox"/>	60. Hernia or rupture		<input checked="" type="checkbox"/>																																																																																																																																																																																																																																																																																																																																										
			61. Any bone or joint trouble, bursitis		<input checked="" type="checkbox"/>																																																																																																																																																																																																																																																																																																																																										
			62. Broken bones or amputations		<input checked="" type="checkbox"/>																																																																																																																																																																																																																																																																																																																																										
			63. Steel pins, plates, or staples in any bones		<input checked="" type="checkbox"/>																																																																																																																																																																																																																																																																																																																																										
<b>E. Have you ever</b>			<b>E. (Contd.) Have you ever</b>																																																																																																																																																																																																																																																																																																																																												
88. Been refused employment or been unable to hold a job or stay in school because of:		<input checked="" type="checkbox"/>	91. Received, is there pending, or have you applied for pension or compensation for existing disability?		<input checked="" type="checkbox"/>																																																																																																																																																																																																																																																																																																																																										
a. inability to perform certain movements?		<input checked="" type="checkbox"/>	92. Had or have you ever been advised to have, any surgical operations?		<input checked="" type="checkbox"/>																																																																																																																																																																																																																																																																																																																																										
b. inability to assume certain positions?		<input checked="" type="checkbox"/>	93. Consulted or been treated by clinics, hospitals, physicians, healers, or other practitioners for other than minor illnesses?		<input checked="" type="checkbox"/>																																																																																																																																																																																																																																																																																																																																										
c. Other medical reasons?		<input checked="" type="checkbox"/>	94. Had any illness or injury other than those already noted?		<input checked="" type="checkbox"/>																																																																																																																																																																																																																																																																																																																																										
89. Been rejected for or discharged from military service because of physical, mental or other reasons?		<input checked="" type="checkbox"/>																																																																																																																																																																																																																																																																																																																																													
90. Been denied or rated up for life insurance?		<input checked="" type="checkbox"/>																																																																																																																																																																																																																																																																																																																																													

DD Form 2492, MAR 87

DoD Exception to SF93 approved by GSA/IRMS 2-87

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



**REMARKS** (Every "Yes" response in items 11 through 94 must be explained in the space below. Give dates and complete details including names of doctors and hospitals or clinics and the current status of the condition. Continue on a separate sheet and attach to this form if additional space is needed.)

- #21 Wears hard contact lenses.
- #22 Allergies--grass, hay and dust.
- #28 and 29 Concussion while playing football - knocked out. Seen in emergency room at Luke General Hospital, Lloyd NY, September 1982, Dr Jones.
- #41 Treated for gingivitis in 1983. No problem since. Dr Fix, Main Street, Aspen CO.
- #66 Flatfeet. Treated with orthotics 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 supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

<b>TYPED OR PRINTED NAME OF EXAMINEE</b>	<b>SIGNATURE</b>	<b>DATE SIGNED</b>
HARRY G. MORAY	<i>Harry G. Moray</i>	10 Dec 88

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

**EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA** (Examiner shall comment on all "Yes" and blank answers (indicating the item number before each comment), develop by interview any additional medical history deemed important, and record significant findings here. If additional space is needed, continue on a separate sheet and attach to this form.)

- #21 Wear hard contact lenses. Lenses removed 22 days prior to exam.
- #22 Allergic rhinitis during spring, treated with OTC medication, well controlled, NCNS.
- #28 and 29 HX of concussion in 1986, LOC 2 minutes, skull x-rays negative, neurological evaluation, WNL, NCNS.
- #41 Treated for givgivitis 1983. Resolved.
- #66 Flatfoot, wears orthotics when participating in sports.
- #80 Car sickness in childhood. No problem now.

<b>TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER</b>	<b>SIGNATURE</b>	<b>DATE SIGNED</b>	<b>NUMBER OF ATTACHED SHEETS</b>
J. D. GODIE, M. D.	<i>J. D. Godie</i>	15 Dec 88	

DD Form 2492 Reverse, MAR 87

Figure 3-2. DD FORM 2492 Reverse, MAR 87

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL HISTORY <small>(This information is for official and medically confidential use only and will not be released to unauthorized persons.) (This form is subject to the Privacy Act of 1974 - See DD Form 2005)</small>				Form Approved OMA No. 0704-0269 Expires Sep 30, 1989							
NAME (Last, First, Middle Initial) MORAY LISA A.		SOCIAL SECURITY NUMBER 011-11-0001		TELEPHONE NO. (include area code) (102) 962-0001							
PURPOSE OF EXAMINATION DODMERB		EXAMINATION FACILITY OR EXAMINER AND ADDRESS (Include Zip Code) USAF CLINIC HANSCOM, HANSCOM FLD MA 01101			DATE OF EXAMINATION 5 May 87						
<b>SECTION I - Mark applicable boxes in items 1 through 10</b>											
1. How would you rate your present health?			6. If you smoke cigarettes how many do you smoke each day?								
<input checked="" type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			<input checked="" type="checkbox"/> Less than 1 pack <input type="checkbox"/> 1 pack <input type="checkbox"/> 1-1/2 packs <input type="checkbox"/> 2 packs or more								
2. How many hours sleep do you usually get at night?			7. On the average, how many times per week do you drink any alcoholic beverages such as beer, wine, or liquor?								
<input type="checkbox"/> 4 or less <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input checked="" type="checkbox"/> 8 <input type="checkbox"/> 9 or more			<input checked="" type="checkbox"/> Never (Skip to Item 9) <input type="checkbox"/> Less than once <input type="checkbox"/> Once or twice <input type="checkbox"/> Three or four <input type="checkbox"/> Five or more								
3. How many days per week do you exercise vigorously (enough to produce a sweat) for at least fifteen minutes?			8. When you drink, how many alcoholic drinks do you have (on the average)?								
<input type="checkbox"/> None <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input checked="" type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 or more								
4. Are you on any special diet?			9. Have you ever used any of the following? N/A								
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			<input type="checkbox"/> Amphetamines <input type="checkbox"/> Barbiturates <input type="checkbox"/> Chemical inhalants <input type="checkbox"/> Cocaine <input type="checkbox"/> Hallucinogens <input type="checkbox"/> Narcotic drugs								
5. Indicate the tobacco products you currently use.			10. What is your marital status?								
<input checked="" type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Snuff (Smokeless tobacco) <input type="checkbox"/> Pipes <input type="checkbox"/> None (Skip to Item 7)			<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed								
<b>SECTION II - Mark each item (11 through 94) "Yes" or "No." If you do not know the answer for a particular item, leave it blank. Every item marked "Yes" must be explained in the REMARKS section on the reverse.</b>											
<b>A. Does your family have a history of</b>		Yes	No	<b>C. (Contd.) Have you ever had or do you now have</b>		Yes	No	<b>C. (Contd.) Have you ever had or do you now have</b>		Yes	No
11. Diabetes or sugar diabetes			<input checked="" type="checkbox"/>	35. Eye trouble (exclude glasses, contact lenses)			<input checked="" type="checkbox"/>	64. Back pain or trouble			<input checked="" type="checkbox"/>
12. Heart trouble or strokes			<input checked="" type="checkbox"/>	36. Vision change or double vision			<input checked="" type="checkbox"/>	65. Paralysis, lameness, or weakness			<input checked="" type="checkbox"/>
13. High blood pressure			<input checked="" type="checkbox"/>	37. Hearing loss			<input checked="" type="checkbox"/>	66. Foot trouble			<input checked="" type="checkbox"/>
14. Cancer			<input checked="" type="checkbox"/>	38. Ear, nose, or throat trouble			<input checked="" type="checkbox"/>	67. Rheumatic fever			<input checked="" type="checkbox"/>
15. Mental condition			<input checked="" type="checkbox"/>	39. Sinusitis or sinus trouble			<input checked="" type="checkbox"/>	68. Tuberculosis or positive TB test			<input checked="" type="checkbox"/>
16. Alcoholism or suicide			<input checked="" type="checkbox"/>	40. Hay fever or allergic rhinitis			<input checked="" type="checkbox"/>	69. Homosexual activity			<input checked="" type="checkbox"/>
17. Seizures or epilepsy			<input checked="" type="checkbox"/>	41. Severe tooth or gum trouble			<input checked="" type="checkbox"/>	70. VD, syphilis, gonorrhea, herpes, etc.			<input checked="" type="checkbox"/>
18. Allergies or Asthma			<input checked="" type="checkbox"/>	42. Thyroid trouble			<input checked="" type="checkbox"/>	71. Skin conditions such as acne, psoriasis, hand or foot rashes, eczema, or dry skin			<input checked="" type="checkbox"/>
19. Arthritis or rheumatism			<input checked="" type="checkbox"/>	43. Chronic cough or lung disease			<input checked="" type="checkbox"/>	72. Adverse reaction to serum, drugs, medicine, food, or bites or stings			<input checked="" type="checkbox"/>
<b>B. Do you or did you ever</b>			<input checked="" type="checkbox"/>	44. Asthma or wheezing			<input checked="" type="checkbox"/>	73. A weight problem			<input checked="" type="checkbox"/>
20. Wear glasses			<input checked="" type="checkbox"/>	45. Unusual shortness of breath			<input checked="" type="checkbox"/>	74. Recent gain or loss of weight			<input checked="" type="checkbox"/>
21. Wear contact lenses or ocular eye retainers			<input checked="" type="checkbox"/>	46. Pain or pressure in chest			<input checked="" type="checkbox"/>	75. Excessive bleeding or easy bruising			<input checked="" type="checkbox"/>
22. Have any allergies			<input checked="" type="checkbox"/>	47. Palpitation or pounding heart			<input checked="" type="checkbox"/>	76. Tumor, growth, cyst, or cancer			<input checked="" type="checkbox"/>
23. Take any medications regularly			<input checked="" type="checkbox"/>	48. Heart trouble or heart murmur			<input checked="" type="checkbox"/>	77. Considered or attempted suicide			<input checked="" type="checkbox"/>
24. Stutter or stammer			<input checked="" type="checkbox"/>	49. High blood pressure			<input checked="" type="checkbox"/>	78. Sleepwalking episodes			<input checked="" type="checkbox"/>
25. Wear a bone or joint brace or support			<input checked="" type="checkbox"/>	50. Coughed up or vomited blood			<input checked="" type="checkbox"/>	79. Easy fatigability			<input checked="" type="checkbox"/>
26. Frequent, severe, or migraine headaches			<input checked="" type="checkbox"/>	51. Stomach, liver, or intestinal trouble			<input checked="" type="checkbox"/>	80. Car, train, sea, or air sickness			<input checked="" type="checkbox"/>
27. Fainting or dizzy spells			<input checked="" type="checkbox"/>	52. Gallbladder trouble or gallstones			<input checked="" type="checkbox"/>	81. X-ray or other radiation therapy			<input checked="" type="checkbox"/>
28. Periods of unconsciousness			<input checked="" type="checkbox"/>	53. Yellow jaundice or hepatitis			<input checked="" type="checkbox"/>	82. Sensitivity to chemicals, dust, sunlight, etc.			<input checked="" type="checkbox"/>
29. Head injury or skull fracture			<input checked="" type="checkbox"/>	54. Hemorrhoids or rectal disease			<input checked="" type="checkbox"/>	83. Learning disabilities or speech problems			<input checked="" type="checkbox"/>
30. Epilepsy, seizures, or convulsions			<input checked="" type="checkbox"/>	55. Black or bloody stools			<input checked="" type="checkbox"/>	<b>D. FEMALES ONLY - Have you ever</b>			<input checked="" type="checkbox"/>
31. Loss of memory or amnesia			<input checked="" type="checkbox"/>	56. Frequent or painful urination			<input checked="" type="checkbox"/>	84. Been treated for a female disorder, painful periods, or cramps			<input checked="" type="checkbox"/>
32. Depression, excessive worry or nervousness, anxiety			<input checked="" type="checkbox"/>	57. Bed wetting since age 12			<input checked="" type="checkbox"/>	85. Had a change in menstrual pattern			<input checked="" type="checkbox"/>
33. Any mental condition or illness			<input checked="" type="checkbox"/>	58. Blood, protein, or sugar in urine			<input checked="" type="checkbox"/>	86. Been pregnant or are you now pregnant			<input checked="" type="checkbox"/>
34. Frequent trouble sleeping			<input checked="" type="checkbox"/>	59. Kidney stone			<input checked="" type="checkbox"/>	87. Taken birth control pills (if yes, give dates and product names)			<input checked="" type="checkbox"/>
35. Frequent or painful urination			<input checked="" type="checkbox"/>	60. Hernia or rupture			<input checked="" type="checkbox"/>				
36. Steel pins, plates, or staples in any bones			<input checked="" type="checkbox"/>	61. Any bone or joint trouble, bursitis			<input checked="" type="checkbox"/>				
37. Broken bones or amputations			<input checked="" type="checkbox"/>	62. Broken bones or amputations			<input checked="" type="checkbox"/>				
38. Frequent trouble sleeping			<input checked="" type="checkbox"/>	63. Steel pins, plates, or staples in any bones			<input checked="" type="checkbox"/>				
<b>E. Have you ever</b>		Yes	No	<b>E. (Contd.) Have you ever</b>		Yes	No				
88. Been refused employment or been unable to hold a job or stay in school because of:			<input checked="" type="checkbox"/>	91. Received, is there pending, or have you applied for pension or compensation for existing disability?			<input checked="" type="checkbox"/>				
a. Inability to perform certain movements?			<input checked="" type="checkbox"/>	92. Had, or have you ever been advised to have, any surgical operations?			<input checked="" type="checkbox"/>				
b. Inability to assume certain positions?			<input checked="" type="checkbox"/>	93. Consulted or been treated by clinics, hospitals, physicians, healers, or other practitioners for other than minor illnesses?			<input checked="" type="checkbox"/>				
c. Other medical reasons?			<input checked="" type="checkbox"/>	94. Had any illness or injury other than those already noted?			<input checked="" type="checkbox"/>				
89. Been rejected for or discharged from military service because of physical, mental or other reasons?			<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>				
90. Been denied or rated up for life insurance?			<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>				

DD Form 2492, MAR 87

DoD Exception to SF93 approved by GSA/IRMS 2-87

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

**REMARKS** (Every "Yes" response in items 11 through 94 must be explained in the space below. Give dates and complete details including names of doctors and hospitals or clinics and the current status of the condition. Continue on a separate sheet and attach to this form if additional space is needed.)

- #21 Wear soft contact lenses.
- #22 Allergies--grass, hay and dust.
- #28 and 29 Concussion while playing softball - knocked out. Seen in emergency room at George General Hospital, Rome NY, July 1985, Dr Henry.
- #41 Treated for gingivitis in 1982. No problem now. Dr Gabelman, Elm Street, Vail CO.
- #66 Flatfeet. Treated with orthotics when participating in sports. Seen by Dr Williams, Salem MA.
- #80 Car sickness in childhood. I've outgrown it. No treatment.

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE  LISA A. MORAY	SIGNATURE <i>Lisa A. Moray</i>	DATE SIGNED <i>16 Dec 88</i>
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**NOTE: HAND TO DOCTOR OR NURSE OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY"**

**EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA** (Examiner shall comment on all "Yes" and blank answers (indicating the item number before each comment), develop by interview any additional medical history deemed important, and record significant findings here. If additional space is needed, continue on a separate sheet and attach to this form.)

- #21 Wear soft contact lenses. Lenses removed 22 days prior to exam.
- #22 Allergic rhinitis during spring, treated with OTC medications, well controlled, NCNS.
- #28 and 29 HX of concussion in 1986, LOC 2 minutes, skull x-rays negative, neurological evaluation, WNL, NCNS.
- #41 Treated for Gingivitis 1982, resolved.
- #66 Flatfeet. Wears orthotics when participating in sports.
- #80 Car sickness in childhood. No problem now.

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER  JOHN J. SMITH, M. D.	SIGNATURE <i>John J. Smith</i>	DATE SIGNED <i>15 Dec 88</i>	NUMBER OF ATTACHED SHEETS
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DD Form 2492 Reverse, MAR 87

Figure 3-4. DD FORM 2492 Reverse, MAR 87

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL HISTORY <small>(This information is for official and medically confidential use only and will not be released to unauthorized persons.) (This form is subject to the Privacy Act of 1974 - See DD Form 2005)</small>				Form Approved OMB No 0704-0269 Expires Sep 30, 1989							
NAME (Last, First, Middle Initial)			SOCIAL SECURITY NUMBER		TELEPHONE NO. (Include area code)						
PURPOSE OF EXAMINATION		EXAMINATION FACILITY OR EXAMINER AND ADDRESS (Include Zip Code)			DATE OF EXAMINATION						
<b>SECTION I - Mark applicable boxes in items 1 through 10</b>											
1. How would you rate your present health?				6. If you smoke cigarettes how many do you smoke each day?							
<input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor				<input type="checkbox"/> Less than 1 pack <input type="checkbox"/> 1 pack <input type="checkbox"/> 1-1/2 packs <input type="checkbox"/> 2 packs or more							
2. How many hours sleep do you usually get at night?				7. On the average, how many times per week do you drink any alcoholic beverages such as beer, wine, or liquor?							
<input type="checkbox"/> 4 or less <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 or more				<input type="checkbox"/> Never (Skip to Item 9) <input type="checkbox"/> Less than once <input type="checkbox"/> Once or twice <input type="checkbox"/> Three or four <input type="checkbox"/> Five or more							
3. How many days per week do you exercise vigorously (enough to produce a sweat) for at least fifteen minutes?				8. When you drink, how many alcoholic drinks do you have (on the average)?							
<input type="checkbox"/> None <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7				<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 or more							
4. Are you on any special diet?				9. Have you ever used any of the following?							
<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Amphetamines <input type="checkbox"/> Barbiturates <input type="checkbox"/> Chemical inhalants <input type="checkbox"/> Cocaine <input type="checkbox"/> Hallucinogens <input type="checkbox"/> Narcotic drugs							
5. Indicate the tobacco products you currently use.				10. What is your marital status?							
<input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Snuff (Smokeless tobacco) <input type="checkbox"/> Pipes <input type="checkbox"/> None (Skip to Item 7)				<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed							
<b>SECTION II - Mark each item (11 through 94) "Yes" or "No." If you do not know the answer for a particular item, leave it blank. Every item marked "Yes" must be explained in the REMARKS section on the reverse.</b>											
<b>A. Does your family have a history of</b>		Yes	No	<b>C. (Contd.) Have you ever had or do you now have</b>		Yes	No	<b>C. (Contd.) Have you ever had or do you now have</b>		Yes	No
11. Diabetes or sugar diabetes				35. Eye trouble (exclude glasses, contact lenses)				64. Back pain or trouble			
12. Heart trouble or strokes				36. Vision change or double vision				65. Paralysis, lameness, or weakness			
13. High blood pressure				37. Hearing loss				66. Foot trouble			
14. Cancer				38. Ear, nose, or throat trouble				67. Rheumatic fever			
15. Mental condition				39. Sinusitis or sinus trouble				68. Tuberculosis or positive TB test			
16. Alcoholism or suicide				40. Hay fever or allergic rhinitis				69. Homosexual activity			
17. Seizures or epilepsy				41. Severe tooth or gum trouble				70. VD, syphilis, gonorrhea, herpes, etc			
18. Allergies or Asthma				42. Thyroid trouble				71. Skin conditions such as acne, psoriasis, hand or foot rashes, eczema, or dry skin			
19. Arthritis or rheumatism				43. Chronic cough or lung disease				72. Adverse reaction to serum, drugs, medicine, food, or bites or stings			
<b>B. Do you or did you ever</b>				44. Asthma or wheezing				73. A weight problem			
20. Wear glasses				45. Unusual shortness of breath				74. Recent gain or loss of weight			
21. Wear contact lenses or ocular eye retainers				46. Pain or pressure in chest				75. Excessive bleeding or easy bruising			
22. Have any allergies				47. Palpitation or pounding heart				76. Tumor, growth, cyst, or cancer			
23. Take any medications regularly				48. Heart trouble or heart murmur				77. Considered or attempted suicide			
24. Stutter or stammer				49. High blood pressure				78. Sleepwalking episodes			
25. Wear a bone or joint brace or support				50. Coughed up or vomited blood				79. Easy fatigability			
				51. Stomach, liver, or intestinal trouble				80. Car, train, sea, or air sickness			
<b>C. Have you ever had or do you now have</b>				52. Gallbladder trouble or gallstones				81. X-ray or other radiation therapy			
26. Frequent, severe, or migraine headaches				53. Yellow jaundice or hepatitis				82. Sensitivity to chemicals, dust, sunlight, etc.			
27. Fainting or dizzy spells				54. Hemorrhoids or rectal disease				83. Learning disabilities or speech problems			
28. Periods of unconsciousness				55. Black or bloody stools				<b>D. FEMALES ONLY - Have you ever</b>			
29. Head injury or skull fracture				56. Frequent or painful urination				84. Been treated for a female disorder, painful periods, or cramps			
30. Epilepsy, seizures, or convulsions				57. Bed wetting since age 12				85. Had a change in menstrual pattern			
31. Loss of memory or amnesia				58. Blood, protein, or sugar in urine				86. Been pregnant or are you now pregnant			
32. Depression, excessive worry or nervousness, anxiety				59. Kidney stone				87. Taken birth control pills (If yes, give dates and product names)			
33. Any mental condition or illness				60. Hernia or rupture							
34. Frequent trouble sleeping				61. Any bone or joint trouble; bursitis							
				62. Broken bones or amputations							
				63. Steel pins, plates, or staples in any bones							
<b>E. Have you ever</b>				Yes	No	<b>E. (Contd.) Have you ever</b>				Yes	No
88. Been refused employment or been unable to hold a job or stay in school because of:						91. Received, is there pending, or have you applied for pension or compensation for existing disability?					
a. Inability to perform certain movements?						92. Had, or have you ever been advised to have, any surgical operations?					
b. Inability to assume certain positions?						93. Consulted or been treated by clinics, hospitals, physicians, healers, or other practitioners for other than minor illnesses?					
c. Other medical reasons?						94. Had any illness or injury other than those already noted?					
89. Been rejected for or discharged from military service because of physical, mental or other reasons?											
90. Been denied or rated up for life insurance?											

DD Form 2492, MAR 87

DoD Exception to SF93 approved by GSA/IRMS 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 explained in the space below. Give dates and complete details including names of doctors and hospitals or clinics and the current status of the condition. Continue on a separate sheet and attach to this form if additional space is needed.)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE	DATE SIGNED
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**NOTE: HAND TO DOCTOR OR NURSE OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY"**

**EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA** (Examiner shall comment on all "Yes" and blank answers (indicating the item number before each comment), develop by interview any additional medical history deemed important, and record significant findings here. If additional space is needed, continue on a separate sheet and attach to this form.)

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	SIGNATURE	DATE SIGNED	NUMBER OF ATTACHED SHEETS
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DD Form 2492 Reverse, MAR 87

Figure 3-6. DD FORM 2492 Reverse, MAR 87

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
REPORT OF DENTAL EXAMINATION**

Privacy Act Statement

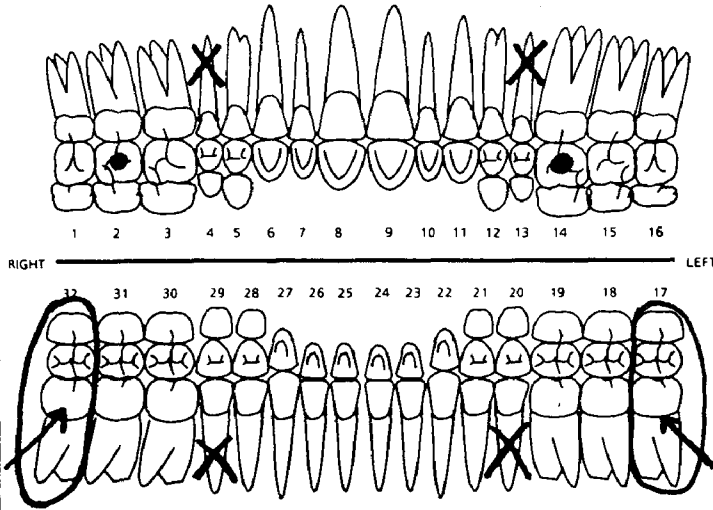
**AUTHORITY:** 10 USC 8012 and Executive Order 9397.  
**PRINCIPAL PURPOSE:** To update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Program, or the Uniformed Services University of Health Sciences (USUHS).  
**ROUTINE USES:** Used 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.

<b>1. APPLICANT'S NAME</b> (Last, First, Middle Initial)  JONES, HARRY W., JR.	<b>2. SSN</b>  100-01-0001
--	----------------------------------

**INSTRUCTIONS**

To be completed at scheduled Examining Center by the Examining Dentist. Panoramic and bitewing radiographs must accompany this examination and be identified by name and SSN. Expedite completed Dental Examination with completed Medical Examination to: DODMERB/DB, US Academy, Colorado Springs, Co 80840-6518.

**3. INDICATE ON THE CHART BELOW, RESTORABLE, NON-RESTORABLE, MISSING TEETH, TEETH REPLACED, SPACES CLOSED AND ANY DEFECTS OR ABNORMALITIES.** (Do not chart restorations)



**4. TYPED OR PRINTED NAME OF EXAMINING DENTIST**  
MARK V. ALLEN, D.D.S.

<b>5. SIGNATURE OF EXAMINING DENTIST</b> <i>Mark V. Allen</i>	<b>6. DATE SIGNED</b> <i>6 Jan 89</i>
--	--

**7. EXAMINING FACILITY**

a. NAME  
Vandenberg Dental Clinic

b. ADDRESS  
USAF Clinic/SGD  
Vandenberg AFB CA 93437-5300

*NOTE:* If examinee has a questionable occlusal relationship, forward diagnostic casts to:  
DODMERB/DB  
US Academy  
Colorado Springs, CO 80840-6518

**8. GENERAL** ("X" Yes or No for each question)  
YES NO

<input checked="" type="checkbox"/>	<input type="checkbox"/>	a. DENTAL CARIES (indicate on chart, do not chart incipienties)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	b. MISSING TEETH, OTHER THAN THIRD MOLARS (indicate on chart by marking "X" through the roots)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	c. NON-RESTORABLE TEETH (indicate on chart by drawing two vertical lines through tooth)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	d. UNERUPTED TEETH (draw circle around the tooth on the chart and indicate position by an arrow)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	e. DEVELOPMENTAL DISTURBANCES IN TEETH (significant enamel hypoplasias, amelogenesis imperfecta, dentinogenesis imperfecta, etc.)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	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.)

<input type="checkbox"/>	<input checked="" type="checkbox"/>	a. HAS THE EXAMINEE EVER HAD A CYST OR TUMOR REMOVED FROM THE MOUTH OR JAWS? (If so, describe)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	b. HISTORY OF ABNORMAL BLEEDING OF THE ORAL TISSUES. (Describe)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	c. ORAL ULCERATIONS, SOFT TISSUE LESIONS, ETC. (Describe)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	d. HISTORY OF CLEFT LIP
<input type="checkbox"/>	<input checked="" type="checkbox"/>	e. HISTORY OF CLEFT PALATE. (1) If yes, is there an oro-nasal or oro-antral fistula present?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	f. HISTORY OF TMJ DISEASE OR PAIN. (Describe)

(Continued on reverse side)

Figure 4-1. DD FORM 2480, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF DENTAL EXAMINATION



**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 Academy, Reserve Officer Training Corps (ROTC) Scholarship Program, or the Uniformed Services University of Health Sciences (USUHS).  
**ROUTINE USES:** Used 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.

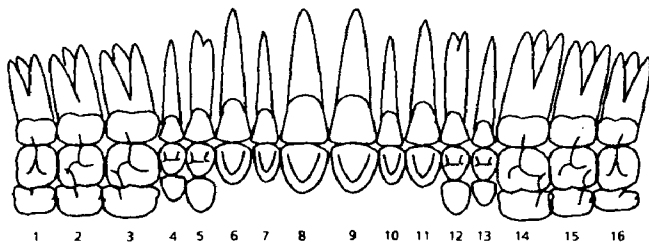
1. APPLICANT'S NAME (Last, First, Middle Initial)

2. SSN

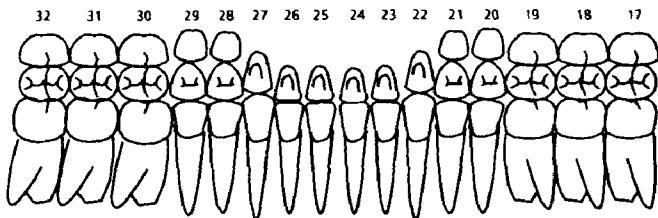
**INSTRUCTIONS**

To be completed at scheduled Examining Center by the Examining Dentist. Panoramic and bitewing radiographs must accompany this examination and be identified by name and SSN. Expedite completed Dental Examination with completed Medical Examination to: DODMERB/DB, US Academy, Colorado Springs, Co 80840-6518.

3. INDICATE ON THE CHART BELOW, RESTORABLE, NON-RESTORABLE, MISSING TEETH, TEETH REPLACED, SPACES CLOSED AND ANY DEFECTS OR ABNORMALITIES. (Do not chart restorations)



RIGHT LEFT



4. TYPED OR PRINTED NAME OF EXAMINING DENTIST

5. SIGNATURE OF EXAMINING DENTIST

6. DATE SIGNED

7. EXAMINING FACILITY

a. NAME

b. ADDRESS

NOTE: If examinee has a questionable occlusal relationship, forward diagnostic casts to:

DODMERB/DB  
US Academy  
Colorado Springs, CO 80840-6518

8. GENERAL ("X" Yes or No for each question)

YES NO

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | a. DENTAL CARIES (indicate on chart, do not chart incipienties).   |
| <input type="checkbox"/> | <input type="checkbox"/> | b. MISSING TEETH, OTHER THAN THIRD MOLARS (indicate on chart by marking "X" through the roots).                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | c. NON-RESTORABLE TEETH (indicate on chart by drawing two vertical lines through tooth).   |
| <input type="checkbox"/> | <input type="checkbox"/> | d. UNERUPTED TEETH (draw circle around the tooth on the chart and indicate position by an arrow).                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | e. DEVELOPMENTAL DISTURBANCES IN TEETH (significant enamel hypoplasias, amelogenesis imperfecta, dentinogenesis imperfecta, etc.). |
| <input type="checkbox"/> | <input type="checkbox"/> | 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.)

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | a. HAS THE EXAMINEE EVER HAD A CYST OR TUMOR REMOVED FROM THE MOUTH OR JAWS? (If so, describe) |
| <input type="checkbox"/> | <input type="checkbox"/> | b. HISTORY OF ABNORMAL BLEEDING OF THE ORAL TISSUES. (Describe)                                |
| <input type="checkbox"/> | <input type="checkbox"/> | c. ORAL ULCERATIONS, SOFT TISSUE LESIONS, ETC. (Describe)                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | d. HISTORY OF CLEFT LIP  |
| <input type="checkbox"/> | <input type="checkbox"/> | e. HISTORY OF CLEFT PALATE.  |
| <input type="checkbox"/> | <input type="checkbox"/> | (1) If yes, is there an oro-nasal or oro-antral fistula present?                               |
| <input type="checkbox"/> | <input type="checkbox"/> | f. HISTORY OF TMJ DISEASE OR PAIN. (Describe)  |

(Continued on reverse side)

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 2480, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF DENTAL EXAMINATION





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

<b>Explanation</b>	<b>Model Entry</b>
<b>Item 1. Applicant Name.</b> (Last, First, MI)	Jones, Harry W., Jr.
<b>Item 2. Social Security Number.</b>	999-99-9999
<b>Item 3. Indicate on the chart:</b> Restorable, nonrestorable, missing teeth, teeth replaced, spaces closed and any defects or abnormalities. Do not chart restorations.	See item 3, attachment 4
<b>Item 4. Typed or Printed Name of Examining Dentist.</b>	CHARLES P. WHITE, Maj, USAF, DC
<b>Item 5 and 6. Signature of Examining Dentist and Date of Dental Examination.</b>	Self-explanatory
<b>Item 7. Examining Facility and Address.</b>	USAF Clinic/SGD Vandenberg AFB CA 93437-5300
<b>Item 8 through 15.</b> 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
<b>Item 16. Remarks.</b> Indicate item of reference, use additional sheet if necessary.	Item 13a. Patient needs prophylaxis and scaling.

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

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**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
CYCLOPLEGIC REFRACTION**

**Privacy Act Statement**

**AUTHORITY:** Title 10, USC 122, and Executive Order 9397.

**PRINCIPAL PURPOSE:** To upgrade 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 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.

<b>1. NAME OF APPLICANT</b> <small>(Last, First, Middle Initial)</small> SCARBOROUGH, JIMMY R		<b>2. SSN OF APPLICANT</b> 001-00-1000	<b>3. DATE OF EXAMINATION</b> 5 May 87
<b>4. ADDRESS OF FACILITY</b> <small>(City, State, Zip Code)</small> USAFA HOSPITAL/SGP USAFA, CO 80840			<b>5. PHONE NO. AT FACILITY</b> <small>(Include Area Code)</small> (303) 472-3577
<b>6. CONTACT LENS DATA</b> <small>(X Applicable Item(s))</small>		<b>7. FAMILY EYE HISTORY</b> <small>(Please indicate the members of your immediate family who wear glasses or contact lenses.) (X applicable item(s))</small>	
<input checked="" type="checkbox"/>	a. I do not wear contact lenses	<input checked="" type="checkbox"/>	a. Father
	b. Soft contact lenses were removed _____ days prior to the above examination		b. Mother
	c. Hard contact lenses were removed _____ days prior to the above examination		c. Brother
	d. Signature of Applicant	<input checked="" type="checkbox"/>	d. Sister
			e. None of my family
<b>8. VISION EVALUATION BEFORE INSTALLATION OF DROPS</b> <small>(Before cycloplegic)</small>			
<b>a. DISTANT VISION</b>		<b>b. CURRENT RX</b> N/A	
OD 20/ 20	Corr to 20/	OD Sphere	Cyl                      Axis
OS 20/ 20	Corr to 20/	OS Sphere	Cyl                      Axis
<b>c. NEAR VISION</b>		<b>9. MEDICATION USED FOR CYCLOPLEGIC</b>	
OD 20/ 20	Corr to 20/	Cyclogel	
OS 20/ 20	Corr to 20/		
<b>10. VISION EVALUATION AFTER CYCLOPLEGIA OBTAINED</b> <small>(NOTE: Correct to 20/20 absolute. Record number of letters missed on 20/20, i.e., 20/20-2, 20/20-3 etc. If unable to correct to 20/20, record best correctable vision. Do not over correct, correct only to 20/20.)</small>			
<b>a. DISTANT VISION CORRECTED TO</b>		<b>b. CYCLO RX</b>	
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	Cyl -0.25                      Axis 090
<b>11. REMARKS</b> <small>(Examiner should list any diagnosis which interferes with visual function which was noted on this examination.)</small>			
<b>12. TYPED OR PRINTED NAME OF EXAMINER</b> ISSAC L. DOETOE, CAPT, USAF, BSC		<b>13. SIGNATURE OF EXAMINER</b> <i>Issac L. Doetoe, Capt. USAF</i>	

DD Form 2369, MAY 86

Previous edition will be used

**Figure 5-1. DD FORM 2369, DOD MEDICAL EXAMINATION REVIEW BOARD CYCLOPLEGIC REFRACTION**

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
CYCLOPLEGIC REFRACTION**

**Privacy Act Statement**

**AUTHORITY:** Title 10, USC 122, and Executive Order 9397.

**PRINCIPAL PURPOSE:** To upgrade 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 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.

<b>1. NAME OF APPLICANT</b> <small>(Last, First, Middle Initial)</small>		<b>2. SSN OF APPLICANT</b>	<b>3. DATE OF EXAMINATION</b>
<b>4. ADDRESS OF FACILITY</b> <small>(City, State, Zip Code)</small>			<b>5. PHONE NO. AT FACILITY</b> <small>(Include Area Code)</small>
<b>6. CONTACT LENS DATA</b> <small>(X Applicable Item(s))</small>		<b>7. FAMILY EYE HISTORY</b> <small>(Please indicate the members of your immediate family who wear glasses or contact lenses.) (X applicable item(s))</small>	
a. I do not wear contact lenses		a. Father	
b. Soft contact lenses were removed                      days prior to the above examination		b. Mother	
c. Hard contact lenses were removed                      days prior to the above examination		c. Brother	
d. Signature of Applicant		d. Sister	
		e. None of my family	
<b>8. VISION EVALUATION BEFORE INSTALLATION OF DROPS</b> <small>(Before cycloplegic)</small>			
<b>a. DISTANT VISION</b>		<b>b. CURRENT RX</b>	
OD 20/	Corr to 20/	OD Sphere	Cyl                      Axis
OS 20/	Corr to 20/	OS Sphere	Cyl                      Axis
<b>c. NEAR VISION</b>		<b>9. MEDICATION USED FOR CYCLOPLEGIC</b>	
OD 20/	Corr to 20/		
OS 20/	Corr to 20/		
<b>10. VISION EVALUATION AFTER CYCLOPLEGIA OBTAINED</b> <small>(NOTE: Correct to 20/20 absolute. Record number of letters missed on 20/20, i.e., 20/20-2, 20/20-3 etc. If unable to correct to 20/20, record best correctable vision. Do not over correct, correct only to 20/20.)</small>			
<b>a. DISTANT VISION CORRECTED TO</b>		<b>b. CYCLO RX</b>	
OD 20/	Corr to 20/	OD Sphere	Cyl                      Axis
OS 20/	Corr to 20/	OS Sphere	Cyl                      Axis
<b>11. REMARKS</b> <small>(Examiner should list any diagnosis which interferes with visual function which was noted on this examination.)</small>			
<b>12. TYPED OR PRINTED NAME OF EXAMINER</b>			<b>13. SIGNATURE OF EXAMINER</b>

DD Form 2369, MAY 86

Previous edition will be used.

Figure 5-2. DD FORM 2369 Reverse, MAYT 86

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
THREE DAY BLOOD PRESSURE AND PULSE CHECK**

**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.

<b>1. NAME OF APPLICANT</b> <i>(Last, First, Middle Initial)</i> MARTINEZ CATHERINE L	<b>2. SSN OF APPLICANT</b> 512-10-0000
--	---

**INSTRUCTIONS TO EXAMINERS**

Studies have shown that the sphygmomanometer cuff must be the correct width for the circumference of the patient's arm. If it is too narrow, the blood pressure readings will be erroneously high. If it is too wide, the readings may be erroneously low. For the average adult, a cuff 12 to 14 cm wide is satisfactory. For arm circumference greater than 28 cm a larger cuff, 18 to 20 cm wide, must be used.

<b>3. ARM CIRCUMFERENCE</b> 9"	<b>4. WIDTH OF THE BLOOD PRESSURE CUFF</b> 14 cm	<b>5. MEDICATION CURRENTLY TAKEN</b> <i>(If none, so state.)</i> NONE
-----------------------------------	---	--

**6. BLOOD PRESSURE AND PULSE READINGS**

a. DAY ONE

(1) DATE	(2) A.M. 0700		(3) P.M. 1300	
	BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE
5 May 87				
(a) SITTING	136/80	80	140/86	88
(b) RECUMBENT	138/78	78	130/80	80
(c) STANDING	130/80	78	138/82	86

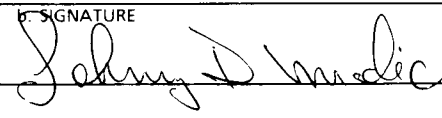
b. DAY TWO

(1) DATE	(2) A.M. 0715		(3) P.M. 1400	
	BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE
6 May 87				
(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

(1) DATE	(2) A.M. 0730		(3) P.M. 1500	
	BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE
7 May 87				
(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/Paramedical Technician)*

<b>a. TYPED OR PRINTED NAME</b> <i>(Last, First, Middle Initial)</i> MEDIC, JOHNNY D	<b>b. SIGNATURE</b> 
<b>c. TITLE</b> AIC, Blood Pressure Recheck Department	

DD Form 2370, MAY 85

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

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
THREE DAY BLOOD PRESSURE AND PULSE CHECK**

**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.

<b>1. NAME OF APPLICANT</b> <i>(Last, First, Middle Initial)</i>	<b>2. SSN OF APPLICANT</b>
--	----------------------------

**INSTRUCTIONS TO EXAMINERS**

Studies have shown that the sphygmomanometer cuff must be the correct width for the circumference of the patient's arm. If it is too narrow, the blood pressure readings will be erroneously high. If it is too wide, the readings may be erroneously low. For the average adult, a cuff 12 to 14 cm wide is satisfactory. For arm circumference greater than 28 cm a larger cuff, 18 to 20 cm wide, must be used.

<b>3. ARM CIRCUMFERENCE</b>	<b>4. WIDTH OF THE BLOOD PRESSURE CUFF</b>	<b>5. MEDICATION CURRENTLY TAKEN</b> <i>(If none, so state.)</i>
-----------------------------	--	--

**6. BLOOD PRESSURE AND PULSE READINGS**

a DAY ONE

(1) DATE	(2) A.M.		(3) P.M.	
	BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE
(a) SITTING				
(b) RECUMBENT				
(c) STANDING				

b DAY TWO

(1) DATE	(2) A.M.		(3) P.M.	
	BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE
(a) SITTING				
(b) RECUMBENT				
(c) STANDING				

c DAY THREE

(1) DATE	(2) A.M.		(3) P.M.	
	BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE
(a) SITTING				
(b) RECUMBENT				
(c) STANDING				

**7. EXAMINER** *(Doctor/Nurse/Paramedical Technician)*

<b>a TYPED OR PRINTED NAME</b> <i>(Last, First, Middle Initial)</i>	<b>b. SIGNATURE</b>
---	---------------------

**c TITLE**

**DD Form 2370, MAY 85**

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

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
UPDATE OF APPLICANT'S MEDICAL EXAMINATION**

Privacy Act Statement

**AUTHORITY:** Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

**PRINCIPAL PURPOSE:** To upgrade 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.

<b>1. TYPED OR PRINTED NAME OF APPLICANT</b> <i>(Last, First, Middle Initial)</i>	<b>2. SSN OF APPLICANT</b>	<b>3. NAME OF PROGRAM APPLIED FOR</b>
LEWIS, JOHN D.	001-01-1001	US Naval Academy

**INSTRUCTIONS**

The Department of Defense Medical Examination Review Board (DODMERB) has been requested to update your Service Academy medical examination report. Our records indicate that you were given a medical examination for last year's selection cycle. If there has been no change in your medical or dental condition, we may be able to use your previous examination report as the basis for determining your medical or dental status for the current selection cycle.

**4. "I hereby certify that I have not received any medical or dental care since the date of my Service Academy medical examination."**  
**a. The above statement** *(X one)*

(1) IS TRUE AND ACCURATE in all respects.

(2) IS NOT TOTALLY ACCURATE *(Explain in detail in 4b below.)*

**b. Detailed explanation why the statement in 4 above is not totally accurate** *(Attach additional pages, if necessary.)*

I had two wisdom teeth removed in Jan 86. I had arthroscopic surgery on my right knee in Nov 85. My knee is fine now.

**5. SIGNATURE OF APPLICANT**

*John D Lewis*

**6. DATE SIGNED**

*6 May 87*

DD Form 2371 MA VRS

Figure 7-1. DD FORM 2371, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) UPDATE OF APPLICANT'S MEDICAL EXAMINATION

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
UPDATE OF APPLICANT'S MEDICAL EXAMINATION**

Privacy Act Statement

**AUTHORITY:** Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

**PRINCIPAL PURPOSE:** To upgrade 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. TYPED OR PRINTED NAME OF APPLICANT <i>(Last, First, Middle Initial)</i>	2. SSN OF APPLICANT	3. NAME OF PROGRAM APPLIED FOR
--	---------------------	--------------------------------

**INSTRUCTIONS**

The Department of Defense Medical Examination Review Board (DODMERB) has been requested to update your Service Academy medical examination report. Our records indicate that you were given a medical examination for last year's selection cycle. If there has been **no change** in your medical or dental condition, we may be able to use your previous examination report as the basis for determining your medical or dental status for the current selection cycle.

4. "I hereby certify that I have not received any medical or dental care since the date of my Service Academy medical examination."

a. The above statement *(X one)*

(1) IS TRUE AND ACCURATE in all respects.

(2) IS NOT TOTALLY ACCURATE *(Explain in detail in 4b below.)*

b. Detailed explanation why the statement in 4 above is not totally accurate *(Attach additional pages, if necessary.)*

5. SIGNATURE OF APPLICANT

6. DATE SIGNED

DD Form 2371 MAY 85

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



**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
STATEMENT OF PRESENT HEALTH**

***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.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.

<b>1. NAME OF APPLICANT</b> <small>(Last, First, Middle Initial)</small> STEWART, ANN M.	<b>2. SSN OF APPLICANT</b> 001-02-1002
---	---

**3. STATEMENT OF PRESENT HEALTH**

Good.

**4. NAME OF MEDICATION(S) AND REASON FOR TAKING** (If you are not on any kind of medications, simply state "NONE.")

Tetracycline for my acne.

**5. DO YOU HAVE ALLERGIES?** (Answer Yes or No. If yes, indicate treatment received; if no allergies, write "NONE.")

**6. REMARKS**

<b>7. SIGNATURE OF APPLICANT</b> <i>Ann M Stewart</i>	<b>8. DATE SIGNED</b> 6 May 87
--	-----------------------------------

DD Form 2372, FEB 86

*Previous edition may be used.*

Figure 8-1. DD FORM 2372, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF PRESENT HEALTH

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
STATEMENT OF PRESENT HEALTH**

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.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 <i>(Last, First, Middle Initial)</i>	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.")*

---



---



---



---

5. DO YOU HAVE ALLERGIES? *(Answer Yes or No. If yes, indicate treatment received; if no allergies, write "NONE.")*

---



---



---

6. REMARKS

---



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7. SIGNATURE OF APPLICANT	8. DATE SIGNED
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DD Form 2372, FEB 86

*Previous edition may be used.*

**Figure 8-2. DD FORM 2372 Reverse, FEB 86**

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
HEART MURMUR EVALUATION**

**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.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.

<b>1. NAME OF APPLICANT</b> <small>(Last, First, Middle Initial)</small> MALIK, BONITA A	<b>2. SSN OF APPLICANT</b> 111-11-1111
---	---

**INSTRUCTIONS TO EXAMINER**

Conditions such as mitral valve prolapse and bicuspid aortic valve are being found increasingly even in the presence of "innocent" or "functional" murmurs. We request that you complete this form which will enable the Department of Defense Medical Examination Review Board to make a proper determination of the applicant's cardiac status.

<b>3. GRADE, AMPLITUDE OR INTENSITY</b> <small>(Use the I-VI Scale)</small> Grade I/VI Systolic Murmur	<b>4. LOCATION</b> <small>(Where is the sound heard best?)</small> Apex
---	--

**5. TIMING DURING THE CARDIAC CYCLE** (e.g., mid-systole)  
Mid Systolic

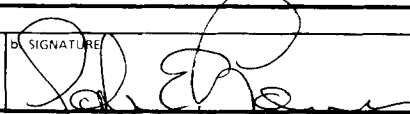
**6. CHARACTER OF THE SOUND** (e.g., crescendo-decrescendo)  
Decrescendo

**7. RADIATION OR TRANSMISSION OF THE SOUND**  
None

**8. OTHER SOUNDS** (e.g., click)  
Mid Systolic Click

**9. RESULT OF ECHOCARDIOGRAM** (Please attach results - NOT TRACINGS.)  
Mitral Valve Prolapse, minimal  
DOPPLER: No evidence of mitral regurgitation

**10. FINAL IMPRESSION AND OTHER COMMENTS**  
Innocent murmur by P.E. and by echo.

<b>11. EXAMINING PHYSICIAN</b>		
<b>a. TYPED OR PRINTED NAME</b> <small>(Last, First, Middle Initial)</small> Lowe, John E	<b>b. SIGNATURE</b> 	<b>c. DATE SIGNED</b> 7 May 87

DD Form 2374, MAY 85

Figure 9-1. DD FORM 2374, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) HEART MURMUR EVALUATION

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
HEART MURMUR EVALUATION**

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.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.

<b>1. NAME OF APPLICANT</b> <i>(Last, First, Middle Initial)</i>	<b>2. SSN OF APPLICANT</b>
--	----------------------------

**INSTRUCTIONS TO EXAMINER**

Conditions such as mitral valve prolapse and bicuspid aortic valve are being found increasingly even in the presence of "innocent" or "functional" murmurs. We request that you complete this form which will enable the Department of Defense Medical Examination Review Board to make a proper determination of the applicant's cardiac status.

<b>3. GRADE, AMPLITUDE OR INTENSITY</b> <i>(Use the I-VI Scale)</i>	<b>4. LOCATION</b> <i>(Where is the sound heard best?)</i>
---	--

**5. TIMING DURING THE CARDIAC CYCLE** *(e.g., mid-systole)*

**6. CHARACTER OF THE SOUND** *(e.g., crescendo-decrescendo)*

**7. RADIATION OR TRANSMISSION OF THE SOUND**

**8. OTHER SOUNDS** *(e.g., click)*

**9. RESULT OF ECHOCARDIOGRAM** *(Please attach results - NOT TRACINGS.)*

**10. FINAL IMPRESSION AND OTHER COMMENTS**

<b>11. EXAMINING PHYSICIAN</b>		
<b>a. TYPED OR PRINTED NAME</b> <i>(Last, First, Middle Initial)</i>	<b>b. SIGNATURE</b>	<b>c. DATE SIGNED</b>

DD Form 2374, MAY 85

Figure 9-2. DD FORM 2374 Reverse, MAY 85

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
PULMONARY FUNCTION STUDIES**

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.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 (Last, First, Middle Initial)**  
DOE, JOHN E

**2. SSN OF APPLICANT**  
000-00-0001

**3. DATE OF EXAMINATION**  
7 May 87

**4. PRIOR TO EXERCISING, PROVIDE THE RESULTS OF A BLOOD AMINOPHYLLINE/  
THEOPHYLLINE TEST**  
Theophylline level: 0 ng/ml

**5. SPECIFIC REFERENCE TO THE STANDARD USED FOR NORMAL**  
Normal therapeutic range 10-20 ng/ml

**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** → 10 mins

**TEST RESULTS**

	a. BEFORE EXERCISE		b. AFTER EXERCISE		c. AFTER BRONCHODILATOR	
	NORMAL (1)	% PREDICTED (2)	NORMAL (1)	% PREDICTED (2)	NORMAL (1)	% PREDICTED (2)
<b>7. TOTAL VITAL CAPACITY</b>	4.50	89%	4.30	85%	4.55	90%
<b>8. FEV-1.0</b>	3.97	94%	3.73	89%	4.08	97%
<b>9. MEFR 25-75 %</b>	4.42	87%	3.99	78%	5.01	98%

**10. WAS WHEEZING PRESENT**

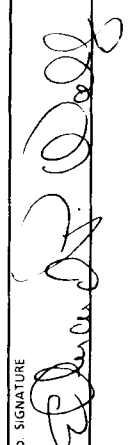
YES	NO
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

**11. IS THE PATIENT TAKING ANY MEDICATIONS? (X one)**

a. YES (Specify medications and usage)	b. NO
	XX

**12. EXAMINER**

**d. TYPED OR PRINTED NAME (Last, First, Middle Initial)**  
Wally, Edward P

**e. SIGNATURE**  


**f. TITLE**  
Chief, Pulmonary Clinic, WBAMC, EP, TX

**DD Form 2375, MAY 85**

Figure 10-1. DD FORM 2375, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) PULMONARY FUNCTION STUDIES

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
PULMONARY FUNCTION STUDIES**

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.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.

<b>1. NAME OF APPLICANT</b> (Last, First, Middle Initial)		<b>2. SSN OF APPLICANT</b>	<b>3. DATE OF EXAMINATION</b>
<b>4. PRIOR TO EXERCISING, PROVIDE THE RESULTS OF A BLOOD AMINOPHYLLINE/THEOPHYLLINE TEST</b>		<b>5. SPECIFIC REFERENCE TO THE STANDARD USED FOR NORMAL</b>	

**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** →

**NOTE:** Administer the bronchodilator 4 minutes after exercise and perform the function test one minute thereafter.

	TEST RESULTS					
	a. BEFORE EXERCISE		b. AFTER EXERCISE		c. AFTER BRONCHODILATOR	
	NORMAL (1)	% PREDICTED (2)	NORMAL (1)	% PREDICTED (2)	NORMAL (1)	% PREDICTED (2)
<b>7. TOTAL VITAL CAPACITY</b>						
<b>8. FEV - 1.0</b>						
<b>9. MEFR 25 - 75 %</b>						
<b>10. WAS WHEEZING PRESENT</b>	YES	NO				
a. BEFORE EXERCISE						
b. AFTER EXERCISE						
c. AFTER BRONCHODILATOR						

**11. IS THE PATIENT TAKING ANY MEDICATIONS?** (X one)

a. YES (Specify medications and usage)	
b. NO	

**12. EXAMINER**

a. TYPED OR PRINTED NAME (Last, First, Middle Initial)	
b. SIGNATURE	
c. TITLE	

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


**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.

<b>1. NAME OF APPLICANT</b> <small>(Last, First, Middle Initial)</small>  FRELIX, ROSS L.	<b>2. SOCIAL SECURITY NUMBER OF APPLICANT</b>  900-00-0009
---	--

**3. "I certify that Applicant (Examinee)**  
(X One)  **a. CAN**  **b. CAN NOT**  
 distinguish and identify objects that are bright RED and bright GREEN," i.e., balls of yarn, colored balls, construction paper. (Do not readminister standard color vision test.)

<b>4. EXAMINER</b>		
a. TITLE OF EXAMINER Color Vision Specialist	b. SIGNATURE OF EXAMINER 	c. DATE SIGNED 7 May 87

DD Form 2377, MAY 85

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.

1. NAME OF APPLICANT <i>(Last, First, Middle Initial)</i>	2. SOCIAL SECURITY NUMBER OF APPLICANT
---	--

3. "I certify that Applicant (Examinee) (X One)  a. CAN  b. CAN NOT

distinguish and identify objects that are bright RED and bright GREEN," i.e., balls of yarn, colored balls, construction paper. *(Do not readminister standard color vision test.)*

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



**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
STATEMENT OF HISTORY REGARDING HEADACHES**

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.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.

**INSTRUCTIONS**

Please provide the following information concerning your history of headaches. Be very specific in your answers. If additional space is needed, please use reverse side of this form.

**1. HOW OFTEN DO YOUR HEADACHES OCCUR?** (e.g., monthly, quarterly, every six months, etc.)

Once a month.

**2. WHEN HEADACHES OCCUR, WHAT IS THEIR FREQUENCY?** (e.g., once a day, twice, three times, etc.)

Once a day.

**3. HOW LONG DO THE HEADACHES USUALLY LAST?** (e.g., 1 hour, 2 hours, 6 hours, etc.)

2 hours

**4. HAVE YOU EVER TAKEN ANY MEDICATIONS FOR YOUR HEADACHES? IF SO, PLEASE EXPLAIN IN DETAIL** (e.g., what medication, usual dose, etc.)

Tylenol

**5. DO HEADACHES INTERFERE WITH NORMAL ACTIVITIES?**

No

**6. LIST ANY OTHER PERTINENT INFORMATION CONCERNING THIS PROBLEM**

N/A

**7. HAS A PHYSICIAN DIAGNOSED YOUR HEADACHES? IF SO, WHAT WERE THE FINDINGS?**

Tension headaches

**B. APPLICANT**

a. SIGNATURE

*Kay Harold*

b. SOCIAL SECURITY NUMBER

001-00-1001

c. DATE SIGNED

5 May 87

DD Form 2378, MAY 85

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

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
STATEMENT OF HISTORY REGARDING HEADACHES**

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.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.

INSTRUCTIONS

Please provide the following information concerning your history of headaches. Be very specific in your answers. If additional space is needed, please use reverse side of this form.

**1. HOW OFTEN DO YOUR HEADACHES OCCUR?** (e.g., monthly, quarterly, every six months, etc.)

--

**2. WHEN HEADACHES OCCUR, WHAT IS THEIR FREQUENCY?** (e.g., once a day, twice, three times, etc.)

--

**3. HOW LONG DO THE HEADACHES USUALLY LAST?** (e.g., 1 hour, 2 hours, 6 hours, etc.)

--

**4. HAVE YOU EVER TAKEN ANY MEDICATIONS FOR YOUR HEADACHES? IF SO, PLEASE EXPLAIN IN DETAIL** (e.g., what medication, usual dose, etc.)

--

**5. DO HEADACHES INTERFERE WITH NORMAL ACTIVITIES?**

--

**6. LIST ANY OTHER PERTINENT INFORMATION CONCERNING THIS PROBLEM**

--

**7. HAS A PHYSICIAN DIAGNOSED YOUR HEADACHES? IF SO, WHAT WERE THE FINDINGS?**

--

**B. APPLICANT**

a. SIGNATURE	b. SOCIAL SECURITY NUMBER	c. DATE SIGNED

DD Form 2378, MAY 85

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

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
STATEMENT OF HISTORY REGARDING HEAD INJURY**

***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.

**1. NAME OF APPLICANT** *(Last, First, Middle Initial)*

BENNETT, TERRY G.

**2. SSN OF APPLICANT**

001-11-1011

**INSTRUCTIONS**

Please answer the following questions regarding head injury. Be very specific in your answers. If additional space is needed, use the reverse side of this form.

**3. HOW DID THE HEAD INJURY OCCUR?**

Playing football

**4. HOW OLD WERE YOU WHEN IT HAPPENED?**

15 years old

**5. WERE YOU UNCONSCIOUS? HOW LONG?**

yes, 2 minutes

**6. DID YOU HAVE A SKULL FRACTURE?**

No

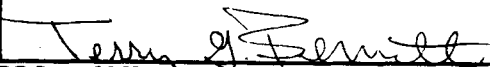
**7. DID YOU HAVE ANY SYMPTOMS AFTER THE INJURY, FOR EXAMPLE; HEADACHES, VOMITING, AMNESIA, DOUBLE VISION, DIZZINESS, ETC.? HOW LONG DID THE SYMPTOM(S) LAST?**

Dizziness for 5 minutes.

**8. WERE ANY ADDITIONAL PROCEDURES ACCOMPLISHED SUCH AS ELECTROENCEPHALOGRAM, BRAIN SCAN, BURR HOLES, PNEUMOENCEPHALOGRAM, ETC.?**

Skull x-rays which were normal.

**9. SIGNATURE OF APPLICANT**



**10. DATE SIGNED**

7 May 87

DD Form 2379, MAY 85

Figure 13-1. DD FORM 2379, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING HEAD INJURY

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
STATEMENT OF HISTORY REGARDING HEAD INJURY**

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.

1. NAME OF APPLICANT *(Last, First, Middle Initial)*

2. SSN OF APPLICANT

**INSTRUCTIONS**

Please answer the following questions regarding head injury. Be very specific in your answers. If additional space is needed, use the reverse side of this form.

3. HOW DID THE HEAD INJURY OCCUR?


4. HOW OLD WERE YOU WHEN IT HAPPENED?


5. WERE YOU UNCONSCIOUS? HOW LONG?


6. DID YOU HAVE A SKULL FRACTURE?


7. DID YOU HAVE ANY SYMPTOMS AFTER THE INJURY, FOR EXAMPLE; HEADACHES, VOMITING, AMNESIA, DOUBLE VISION, DIZZINESS, ETC.? HOW LONG DID THE SYMPTOM(S) LAST?


8. WERE ANY ADDITIONAL PROCEDURES ACCOMPLISHED SUCH AS ELECTROENCEPHALOGRAM, BRAIN SCAN, BURR HOLES, PNEUMOENCEPHALOGRAM, ETC.?


9. SIGNATURE OF APPLICANT

10. DATE SIGNED


DD Form 2379, MAY 85

Figure 13-2. DD FORM 2379 Reverse, MAY 85

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
STATEMENT OF HISTORY REGARDING SLEEPWALKING**

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.

1. NAME OF APPLICANT (Last, First, Middle Initial)

TIPTOE, JOHNNY T.

2. SSN OF APPLICANT

100-01-1000

**INSTRUCTIONS**

Please answer the following questions regarding sleepwalking. Be very specific in your answers. If additional space is needed, use the reverse side of this form.

3. HOW FREQUENT ARE EPISODES OF SLEEPWALKING?

Twice a month

4. WHEN DID YOU LAST SLEEPWALK (month and year) (age)?

April 1987, 17 years old

5. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR SLEEPWALKING.

I get up in the middle of the night and walk into the living room. I wake up in the living room and don't remember how I got there.

6. SIGNATURE OF APPLICANT

*Johnny T. Tiptoe*

7. DATE SIGNED

1 May 87

DD Form 2380, MAY 85

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 MOTION SICKNESS**

**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.

**1. NAME OF APPLICANT** *(Last, First, Middle Initial)*  
MELLS, FRED D.

**2. SSN OF APPLICANT**  
100-00-0010

**INSTRUCTIONS**

Please answer the following questions regarding motion sickness. Be very specific in your answers. If additional space is needed, use the reverse side of this form.

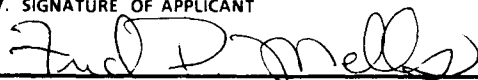
**3. TYPE OF MOTION SICKNESS (SUCH AS, AIR, TRAIN, CAR, SEA, SWING, CARNIVAL RIDES, ETC.).**  
Sea sickness

**4. WHAT AGE DID IT FIRST HAPPEN?**  
14 years old

**5. HOW SEVERE AND FREQUENT ARE EPISODES?**  
I was sick all day while deep sea fishing. This happened only once.

**6. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR MOTION SICKNESS.**  
I have gone fishing since and not gotten sea sick.

**7. SIGNATURE OF APPLICANT**



**8. DATE SIGNED**

2 Apr 87

DD Form 2381, MAY 85

Figure 15-1. DD FORM 2381, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING MOTION SICKNESS

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
STATEMENT OF HISTORY REGARDING MOTION SICKNESS**

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.

1. NAME OF APPLICANT <i>(Last, First, Middle Initial)</i>	2. SSN OF APPLICANT
---	---------------------

**INSTRUCTIONS**

Please answer the following questions regarding motion sickness. Be very specific in your answers. If additional space is needed, use the reverse side of this form.

3. TYPE OF MOTION SICKNESS (SUCH AS, AIR, TRAIN, CAR, SEA, SWING, CARNIVAL RIDES, ETC.).


4. WHAT AGE DID IT FIRST HAPPEN?


5. HOW SEVERE AND FREQUENT ARE EPISODES?


6. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR MOTION SICKNESS.


7. SIGNATURE OF APPLICANT	8. DATE SIGNED
---------------------------	----------------

DD Form 2381, MAY 85

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



**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
STATEMENT OF HISTORY REGARDING HAY FEVER, SINUSITIS, ASTHMA AND/OR ALLERGIES**

*Privacy Act Statement*

**AUTHORITY:** Title 10, US Code 133, 3012, 5031, 8012 and EO 9397, November 1943 (SSN).  
**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.

<b>1. NAME OF APPLICANT</b> (Last, First, Middle Initial) MARPEL, MARY M.	<b>2. SSN OF APPLICANT</b> 000-01-0000
--	---

**INSTRUCTIONS**

Please answer the following questions regarding hay fever, sinusitis, asthma and/or allergies. Be very specific in your answers. If additional space is needed, use the reverse side of this form.

**3. NUMBER AND APPROXIMATE DATES OF ATTACKS OR EPISODES.**  
5 episodes: 23 May 85, 14 July 85, 1 October 85, 30 January 86 and 14 Apr 87.

**4. SIGNS, SYMPTOMS AND DURATION OF ATTACKS.**  
Wheezing, shortness of breath.

**5. TYPE AND AMOUNT OF MEDICATION USED AND LENGTH OF TREATMENT.**  
Theodur 300 mgs, 3 times a day for 30 days.

**6. TYPE OF AND DURATION OF HYPOSENSITIZATION (DESENSITIZATION) (IF ANY) EMPLOYED, GIVING INCLUSIVE DATES.**  
N/A

**7. HAS MAINTENANCE DOSE BEEN ATTAINED?**  
Proventil as needed prior to exercises.

**8. AGE AT LAST ATTACK OF ASTHMA AND DATE LAST ASTHMA MEDICATION WAS USED.**  
16 years old

**9. IS THERE ANY HISTORY OF ALLERGIC SKIN DISORDER? IF YES, PLEASE EXPLAIN.**  
No

<b>10. SIGNATURE OF APPLICANT</b> <i>Mary M Marpel</i>	<b>11. DATE SIGNED</b> <i>14 May 87</i>
---	--

DD Form 2382, MAY 87

*Previous edition may be used.*

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

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
STATEMENT OF HISTORY REGARDING HAY FEVER, SINUSITIS, ASTHMA AND/OR ALLERGIES**

***Privacy Act Statement***

**AUTHORITY:** Title 10, US Code 133, 3012, 5031, 8012 and EO 9397, November 1943 (SSN).  
**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.

1. NAME OF APPLICANT <i>(Last, First, Middle Initial)</i>	2. SSN OF APPLICANT
---	---------------------

**INSTRUCTIONS**

Please answer the following questions regarding hay fever, sinusitis, asthma and/or allergies. Be very specific in your answers. If additional space is needed, use the reverse side of this form.

3. NUMBER AND APPROXIMATE DATES OF ATTACKS OR EPISODES.


4. SIGNS, SYMPTOMS AND DURATION OF ATTACKS.


5. TYPE AND AMOUNT OF MEDICATION USED AND LENGTH OF TREATMENT.


6. TYPE OF AND DURATION OF HYPOSENSITIZATION (DESENSITIZATION) (IF ANY) EMPLOYED, GIVING INCLUSIVE DATES.


7. HAS MAINTENANCE DOSE BEEN ATTAINED?

8. AGE AT LAST ATTACK OF ASTHMA AND DATE LAST ASTHMA MEDICATION WAS USED.

9. IS THERE ANY HISTORY OF ALLERGIC SKIN DISORDER? IF YES, PLEASE EXPLAIN.


10. SIGNATURE OF APPLICANT	11. DATE SIGNED
----------------------------	-----------------

DD Form 2382, MAY 87

*Previous edition may be used*

**Figure 16-2. DD FORM 2382 Reverse, MAY 87**

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
STATEMENT OF USE REGARDING MEDICATION**

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.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.

<b>1. NAME OF APPLICANT</b> <small>(Last, First, Middle Initial)</small> WHITE, REBECCA L.	<b>2. SSN OF APPLICANT</b> 010-00-1010
---	---

INSTRUCTIONS

Please answer the following questions regarding use of medication. Be very specific in your answers. If additional space is needed, use reverse side.

**3. TYPE OF MEDICATION**  
Actifed

**4. REASON FOR USAGE**  
Allergies

**5. HOW LONG HAVE YOU TAKEN THIS MEDICATION?**  
13 days

**6. HAVE YOU TAKEN ANY OTHER MEDICATION IN THE LAST 90 DAYS PRIOR TO PHYSICAL?** (List type and reason for usage.)  
No

<b>7. SIGNATURE OF APPLICANT</b> <i>Rebecca L White</i>	<b>8. DATE SIGNED</b> 5 May 87
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DD Form 2383, MAY 85

Figure 17-1. DD FORM 2383, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF USE REGARDING MEDICATION

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
STATEMENT OF USE REGARDING MEDICATION**

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.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.

<b>1. NAME OF APPLICANT</b> <small>(Last, First, Middle Initial)</small>	<b>2. SSN OF APPLICANT</b>
--	----------------------------

**INSTRUCTIONS**

Please answer the following questions regarding use of medication. Be very specific in your answers. If additional space is needed, use reverse side.

**3. TYPE OF MEDICATION**

---



---



---

**4. REASON FOR USAGE**

---



---



---



---

**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.)

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<b>7. SIGNATURE OF APPLICANT</b>	<b>8. DATE SIGNED</b>
----------------------------------	-----------------------

DD Form 2383, MAY 85

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

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

***Privacy Act Statement***

**AUTHORITY:** Title 10, USC 133, 3012, 5031, 8012 and EO 9397, November 1943 (SSN).

**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.

**1. NAME OF APPLICANT** *(Last, First, Middle Initial)*  
MOORE, JOHN X.

**2. SSN OF APPLICANT**  
000-00-0100

**INSTRUCTIONS TO EXAMINERS**

Please read reverse side of this form before administering this test.

Indicate by letters in each given block which colors were observed by the examinee for each run of the test (e.g., R/W, G/R, etc.).

	1	2	3	4	5	6	7	8	9	NUMBER OF ERRORS PER RUN
<b>1st RUN</b>	G/R	W/W	G/W	G/R	R/G	W/R	W/W	G/W	R/R	3
<b>2nd RUN</b>	G/R	W/G	G/W	G/G	R/G	W/R	W/W	R/W	R/R	∅
<b>3rd RUN</b>	G/R	W/R	G/W	G/G	R/G	W/R	W/W	R/W	R/R	∅

**3. REMARKS** *(Continue on reverse if necessary)*

**4. SIGNATURE OF EXAMINER**

*J. Cheker USAF*

**5. DATE SIGNED**

16 Jun 87

DD Form 2489, FEB 87

Figure 18-1. DD FORM 2489, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) 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, must be removed 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 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**

Privacy Act Statement

**AUTHORITY:** Title 10, USC 133, 3012, 5031, 8012 and EO 9397, November, 1943 (SSN).

**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.

1. NAME OF APPLICANT (Last, First, Middle Initial)

2. SSN OF APPLICANT

**INSTRUCTIONS TO EXAMINERS**

Please read reverse side of this form before administering this test.

Indicate by letters in each given block which colors were observed by the examinee for each run of the test (e.g., R/W, G/R, etc.).

	1	2	3	4	5	6	7	8	9	NUMBER OF ERRORS PER RUN
1st RUN										
2nd RUN										
3rd RUN										

3. REMARKS (Continue on reverse if necessary)

4. SIGNATURE OF EXAMINER

5. DATE SIGNED

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, must be removed 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 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



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## ADDITIONAL INSTRUCTIONS FOR PERFORMING MEDICAL 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.

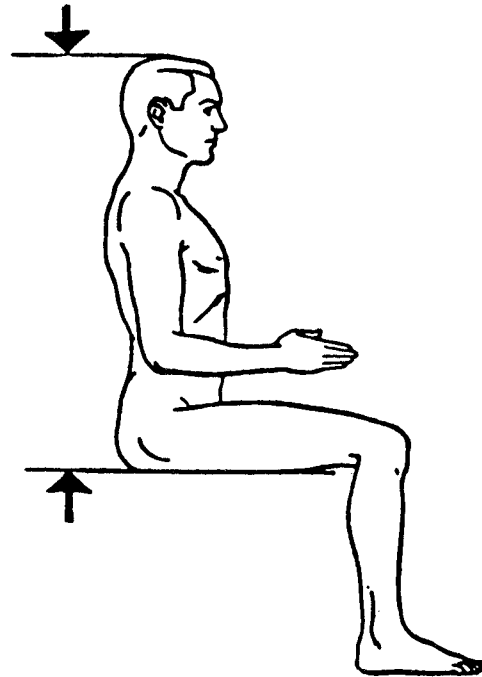
"You wish to know all about my grandfather. Well, he is nearly 93 years old; he dresses himself in an ancient black frock coat, usually minus several buttons; yet, he still thinks as swiftly as ever. A long flowing beard clings to his chin giving those who observe him a pronounced feeling of the utmost 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 day. 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

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**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 45o, 90o, 135o, and 180o, 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

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## **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.

**UNCLASSIFIED**

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