General Instructions for Completion of USPHS Medical Examination Forms DD-2807-1 "Report of Medical History" and DD-2808 "Report of Medical Examination"

These forms are available at http://dcp.psc.gov/DCPForms.asp and are used for Medical Examinations intended for the purposes of Retention, Assimilation, Retirement/Separation, Long Term Training, Limited Tour Removal, and other medical information reporting purposes. **Failure to complete the forms according to these instructions will delay your medical clearance.**

A complete physical examination is required every five years. Each five-year periodic physical examination is valid through the end of the month from the date signed by the examiner. Thus, if you completed your medical examination in June of 2005, your medical clearance expires June 30, 2010.

Current DD-2807-1 "Report of Medical History" no older than one year will be required for Assimilation, Permanent Promotion, and Long Term Training.

A complete physical exam consists of:

DD-2807-1 "Report of Medical History",
DD-2808 "Report of Medical Examination",
PHS-6355 "Applicant Dental Exam Form" (per instructions #43)
Reports of all lab tests
Other pertinent medical documents-age related
Disclosure Statement

These documents must be completed per these instructions and **mailed** to:

Office of Commissioned Corps Support Services
Medical Affairs Branch
Attn: Physical Exams
5600 Fishers Lane, Room 4C-04
Rockville, MD 20857-0001

COPIES of POOR QUALITY AND FAXES WILL NOT BE ACCEPTED

Always keeps copies for your records
Make sure your Name and Social Security Number or PHS number is on ALL documents sent to MAB

DO NOT mail this page to MAB

Required Disclosure Statement
And
Instructions Statement of Understanding

I certify that I have reviewed the foregoing information and that it is true and complete to the best of my knowledge. I understand that falsification of information on the DD-2807-1 "Report of Medical History" and other Government forms is punishable by disqualification, separation, fine and/or imprisonment.

My signature on this document **also indicates that I have read and followed the instructions for completion of the physical exam forms: DD-2808 and DD-2807-1.** I understand that submission of an incomplete history and/or physical exam will result in the delay of the review of my physical exam and that the forms will be returned to me for completion. My medical history is required to be on the DD-2807-1 "Report of Medical History" and my physical exam is required to be on the DD-2808 "Report of Medical Examination". Both are to be completed according to the instructions on the following pages.

_____ _____

Officer's Signature Social Security Number

_____ _____

Printed Name Date

This form **must** be **signed, dated,** and **MAILED** to **MAB** along with all other required documents.

All forms are not complete until they are signed and dated.

Faxed copies will NOT be accepted.
All physical exams must be on the above noted forms.

Instructions for Completion of DD-2807-1
"Report of Medical History"

Items 1-5 on page 1 of 3 MUST be completed including information on the top of page 2 of 3 and 3 of 3:
Last Name, **First** Name, **Middle** Name **and** Social Security Number

1. **Last** Name, **First** Name, **Middle** Name
2. **Social Security Number**-*must* be included
3. **TODAY'S date**-use **YYYY-MM-DD** numerical format

4a. **Home address**; 4b. **Home telephone** (include area code);

5. **Examining Location and Address**

6a. **Service**-*write in* "USPHS"
b. **Component**-"Active Duty"
c. **Purpose of Examination:** you may check one or more of the choices listed in this section, e.g.:
Retention (a.k.a. 5 yr PE)
Separation
Retirement (and **add**: "Length of Service", "Temporary", or "Age")
OR check the box "Other" and write in:
Assimilation
Permanent Promotion
5-year Periodic Physical
Long-term Training
Fitness for Duty
Limited Tour Re-evaluation

7a. **Position**-your rank
b. **Usual Occupation**-category

8. **Current Medications**-list all medications you currently take
9. **Allergies**-medication and non-medication allergies
10. **HAVE YOU EVER HAD OR DO YOU NOW HAVE**
Answer YES or NO to items 10-28, **(If your response to question 14c is "No", please provide explanation.)**
-***REMEMBER*** *the question asks, "Have You Ever Had or do You Now Have"*

29. **Explanation of "YES" answer**(s)
Describe in detail all yes answer(s); give date(s) of problem(s), name(s) of doctor(s) and/or hospital(s), treatment(s) given, current medical status, and limitations.

30. **Examiner's Summary and Elaboration of All Pertinent Data REQUIRED For 5 Year Physical –** optional for all other.
Complete as described in this section.
a. **Comments**-of examining provider
b. **Typed or Printed Name of Examiner**-Last, First, Middle Initial
c. **Signature**-of provider
d. **DATE SIGNED**-YYYY-MM-DD format
(THIS DOCUMENT IS INCOMPLETE IF LEFT UNDATED)

Instructions for DD-2808
"Report of Medical Examination"

Items 1-10a, 15-16, and information at the top of page 2 and 3 MUST be provided. Items 10b-14c are optional.

1. **Date of Examination**-use YYYY-MM-DD numerical format
2. **Social security number**-*required*
3. **Last** name-**First** name-**Middle** name (suffix)
4. **Home Address**-*required*
5. **Home Telephone Number** (include area code)
6. **Grade**-rank
7. **Date of Birth**-use YYYY-MM-DD numerical format
8. **Age**
9. **Sex**-check female or male

10a. **Racial Category**-this is needed for **medical** purposes only
b. **Ethnic Category**-optional

11a. & b. **Total years government service**-optional

12. **Agency**-IHS, CDC, BOP, NIH, etc.
13. **Organization Unit and UIC/Code**-leave blank

14a. **Rating or Specialty**
b. **Total Flying Time**
c. **Last six months**-leave 14a-c blank, unless you are an Aviator

15a. **Service**-*write in* "USPHS"
b. **Component**-"Active Duty"
c. **Purpose of Examination:** you may check one or more of the choices listed in this section, e.g.:

Retention (a.k.a. 5 yr PE)
Separation
Retirement (and **add**: "Length of Service", "Temporary", or "Age")

OR check the box "Other" and write in:

Assimilation
Permanent Promotion
CCRF
Long-term Training
Fitness for Duty
Limited Tour Re-evaluation

16. **Name of Examining Location, and Address** (include ZIP Code)

Clinical Evaluation section

17.-42. **and** 35. **Feet (continued)**
This section is to be completed by your provider(s). More than one provider may use this section.

44. **Notes**-provider(s) should follow the instructions in this section.

The Clinical Evaluation ***must*** include**:**

- Rectal exam with fecal occult blood testing (FOBT) x 3 for colorectal cancer screening. (≥ age 40)
- Flexible-sigmoidoscopy or colonoscopy (≥age 50 is **required**)
- **Copy** of recent EKG (within last 12 months) with interpretation (>age 40)-**required**
- Chest X-ray-required for everyone with a positive PPD along with documentation of any prophylactic treatment and written request for a PPD waiver in accordance with "Manual Circular 377"; otherwise optional or as clinically indicated
- Pulmonary Function Test-as clinically indicated

Additional tests/exams for Males:

- PSA (≥ age 50)-submit lab results
- Prostate exam (≥ age 40)

Additional tests/exams for Females:

- Mammogram (baseline radiologic mammogram report between the ages of 35-40- **required**
  Radiologic mammogram report results must be included with every PE (≥age 50)-**required**
- Pap-results (cervical cytology report) **and** report of pelvic physical findings **must** be within one year of the date of every 5 year physical-**required**

43. **Dental Defects and Disease**-
    Dentists **complete form PHS 6355**;
    Medical providers- **Acceptable or Not acceptable**-check the correct response;
    Class-leave blank
35. **FEET**-circle category

Page 2 of 3 Pages...Instructions

Name and Social Security at top of page- *must be completed*

Laboratory Findings section
*Dated and printed lab report findings **MUST** be submitted*

45. **Urinalysis**-Complete urinalysis (with microscopic if indicated)
46. **Urine HCG**-run test if indicated
47. **Hemoglobin/Hematocrit results along with CBC** report (with differential if WBC is abnormal) - ***required***
48. **Blood Type**-complete **only if** you do not know your blood type
49. **HIV**-optional
50. **Drugs**-optional
51. **Alcohol**-optional

52. **Other**-use as needed

Laboratory tests must be fasting (only water is allowed for 8 hours prior to test) **and must include:**

- Glucose
- Chem-20 (**electrolytes, metabolic panel, lipid panel)**-if lipids are elevated, you must submit evaluation report from your medical provider addressing all coronary artery disease risk factors and treatment recommendations- **required**
- Blood type-**if** you do not know your blood type
- Hgb A1C **for diabetics or as clinically indicated**

53. **Height**-without shoes- **required**
54. **Weight**-**required**
55. **Min wgt-Max wgt/Max BF%**-body fat test results as indicated for muscular individuals
56. **Temperature**-optional
57. **Pulse**-***required***
58. **Blood Pressure**-***required***
    a. Upon arrival in providers office;
    b. & c. if indicated

Eye Exam by Optometry

59. **Red/Green** & 60. **Other Vision Test**-optional
61. **Distant Vision**-***required***
62. **Refraction by Auto-refraction or Manifest**-optional
63. **Near Vision**-***required***
64. **Heterophoria**-as clinically indicated
65. **Accommodation**-as clinically indicated
66. **Color Vision**-optional
67. **Depth Perception**-optional
68. **Field of Vision**-***required for diabetics***
69. **Night Vision**-optional
70. **Intraocular Tension**-***required for age ≥50***

Audiometer testing

71a. **Numerical Values**-***required* 72.** b. leave blank
72a. **Reading Aloud** & 72b. **Valsalva**-optional
73. **Notes and Significant or Interval History**-use as indicated

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Name and Social Security Number at top of page-**must be completed**

74a. & b. **Examinee/Applicant**-will be used by some Military Facilities. *Civilian providers leave these blank.*

75. I have been advised of my disqualifying condition.
    a. **Signature of Examinee** & b. **Date**-leave blank

76. **Significant or Disqualifying Defects**-used in some MTFs, *civilian providers leave this blank.*
77. **Summary of Defects and Diagnoses**-list diagnoses.
78. **Recommendations-Further Specialist Examinations Indicated**-referrals to other health care providers are written in this space.
79. **MEPS Workload (for MEPS use only)** and 80. **Medical Inspection Date** leave blank
81a.-82a. **Typed or Printed Name of Physician or Examiner** and 81b-82b. **Signature**-your providers *must* complete these items *and include the date of the exam.*
83a. **Typed or Printed Name of Dentist or Physician (Indicate which)** use as needed
84a. & b.-86. Leave blank.
87. **Number of Attached Sheets**-Optional

Physical Examinations must be submitted on the DD-2808.

Make sure your name, social security number and/or PHS number is on every page submitted to MAB's physical exam section.

Physical Examinations must be complete according to these instructions when submitted to MAB.

DO NOT FAX ANY PHYSICAL EXAMINATION DOCUMENTS.

Do Not Mail these Instructions to MAB