

ACCESSIONS MEDICAL HISTORY REPORT

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PRIVACY ACT STATEMENT

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

PURPOSE: To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.

ROUTINE USE(S): The Routine Uses are listed in the system of records notice found at: <https://www.federalregister.gov/documents/2021/04/21/2021-08286/privacy-act-of-1974-system-of-records>

DISCLOSURE: Voluntary, however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or \$10,000 fine, or both), to anyone making a false statement. If you are selected for enlistment, commission or entrance into a commissioning program based on a false statement, you may be subject to prosecution under the Uniform Code of Military Justice or to administrative separation proceedings for discharge, and could receive a less than honorable discharge.

SECTION I – APPLICANT INFORMATION

1. LAST NAME – FIRST NAME – MIDDLE INITIAL (<i>Suffix</i>)	2. AGE	3. DATE OF BIRTH (YYYYMMDD)	4.a. SOCIAL SECURITY NUMBER	4.b. DoD ID NUMBER (<i>If applicable</i>)
5. (<i>X each item</i>) a. SEX (<i>at birth</i>) <input type="checkbox"/> Male <input type="checkbox"/> Female		b. GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		6.a. SERVICE PROCESSING FOR (<i>X as applicable</i>) <input type="checkbox"/> Army <input type="checkbox"/> Space Force <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard <input type="checkbox"/> Other: _____
7. PURPOSE OF EXAMINATION (<i>X as applicable</i>) <input type="checkbox"/> Enlistment <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Commission <input type="checkbox"/> ROTC Scholarship <input type="checkbox"/> Other: _____		6.b. COMPONENT (<i>X as applicable</i>) <input type="checkbox"/> Regular <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard		
8. POSITION (<i>If current Federal Employee</i>) (<i>Job Title, Grade, Component</i>)				

SECTION II - APPLICANT (OR PARENT/GUARDIAN) AUTHORIZATION STATEMENT

- I Have read and understand the warning and penalties that are associated with providing a false statement.
- I Agree that all protected health information and personally identifiable information (PHI/PII) or data disclosed by myself or others on my behalf with my consent during the accession process is no longer protected by federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules and may be further disseminated as needed.
- I Authorize release of medical records and information relating to grades, performance, individual education plans, and disciplinary proceedings. Under the Family Educational Rights and Privacy Act (FERPA), United States Military Entrance Processing Command (USMEPCOM)/Department of Defense Medical Examination Review Board (DoDMERB) is authorized to receive all of my education/disciplinary records for evaluation of my suitability for Military Service.
- I Understand that a medical examination is part of the accession evaluation, may require several visits to the Military Entrance Processing Station (MEPS), or DoDMERB contracted medical center. I may have blood work and/or other medical tests, procedures such as cerumen removal, and/or specialty consultations performed as part of my processing.
- I Understand that the results of the examination, tests, and consults are not performed as part of an individual healthcare treatment plan, but will be reviewed and considered as part of my accession application file.
- I Understand that the MEPS/DoDMERB medical staff are not my healthcare providers. If I do not receive notice of an abnormal result of a test or a consultation, I am not to assume that the result is normal. Furthermore, if any test or consultation results are abnormal, then I am responsible for obtaining those results from the MEPS/DoDMERB contracted medical center. I am also responsible for any necessary follow-up evaluations and/or treatment. If I am notified to return to the MEPS/DoDMERB contracted medical center to discuss medical results, it is my responsibility to take quick action to return to the MEPS/DoDMERB contracted medical center.
- I Understand that neither USMEPCOM nor DoDMERB are financially responsible for costs associated with any necessary follow-up evaluations and/or treatment based on my screening evaluation.
- I Understand that any concerns that I have about my health and healthcare are my responsibility to address with my personal healthcare provider(s).
- I Understand that I must provide required documentation regarding my health history which, upon my accession, will become part of my Service member lifecycle medical treatment record.
- I Authorize a MEPS/DoDMERB contracted medical center to perform my accession medical evaluation.
- I Understand that I have the right to refuse to sign this authorization, however I also understand that failure to do so will prevent my further processing.
- I Understand that this authorization will expire four years from the date of the signature below, or sooner if written request is received by the USMEPCOM/DoDMERB Privacy Office. I have the right to revoke this authorization in writing, except to the extent that the DoD has acted in reliance on this information.

1. APPLICANT AUTHORIZATION AND CERTIFICATION

I Certify that the information on this form is true and complete to the best of my knowledge and belief, and no person has advised me to conceal or falsify any information about my medical and mental/behavioral health history.

a. SIGNATURE	b. DATE SIGNED (YYYYMMDD)
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2. PARENT OR GUARDIAN AUTHORIZATION (*Signature is mandatory if applicant is a minor*)

a. NAME (<i>Last, First, Middle Initial</i>)	b. SIGNATURE	c. DATE SIGNED (YYYYMMDD)
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3. RECRUITING REPRESENTATIVE CERTIFICATION: (*If applicable*) I certify that all applicant information above is complete and true to the best of my knowledge.

a. NAME (<i>Last, First, Middle Initial</i>)	b. RECRUITER IDENTIFICATION NUMBER	c. SIGNATURE	d. DATE SIGNED (YYYYMMDD)
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CUI (when filled in)

LAST NAME – FIRST NAME – MIDDLE INITIAL <i>(Suffix)</i>		SOCIAL SECURITY NUMBER		DoD ID NUMBER <i>(If applicable)</i>		
SECTION III - MEDICAL HISTORY						
1. Medications: any prescription or over the counter medication(s) taken regularly or as needed <i>(list each and explain in SECTION IV)</i>			2. Allergies: reaction to food(s), insect bites/stings, medication(s) or other substances <i>(list each and explain in SECTION IV)</i>			
Read each of the following questions and answer by checking "YES" or "NO". Every question must be answered. Every "YES" answer must be explained in SECTION IV. Explain each item to the best of your ability. Your medical records may be requested to clarify your medical history.						
HAVE YOU EVER HAD OR DO YOU NOW HAVE:			YES	NO	HAVE YOU EVER HAD OR DO YOU NOW HAVE:	
YES			YES	NO	YES	
NO			YES	NO	NO	
EYES/VISION:			UPPER EXTREMITIES: <i>(Continued)</i>			
3. Double vision					60. Dislocated shoulder, elbow, or wrist	
4. Detached retina or surgery to repair a detached retina					LOWER EXTREMITIES:	
5. Keratoconus, glaucoma, cataracts or surgery for cataracts					61. Foot conditions such as plantar fasciitis, heel spur, or painful bunions	
6. Vision correction procedure such as Lasik, PRK, or lens implant					62. Knee injury resulting in ligament/cartilage tear, instability, or locking	
7. Night blindness					63. Any pain, swelling, weakness, numbness, or stiffness of the hip, knee, ankle, foot, or toes	
8. Any other eye condition, injury, or surgery/procedure					64. Dislocated hip, knee, ankle, or foot	
EARS/HEARING:			MISCELLANEOUS CONDITIONS OF THE EXTREMITIES:			
9. Cholesteatoma					65. Bone, muscle, or joint deformity, injury, or persistent pain/swelling	
10. Ear drum perforation or tubes inserted into the ear drum(s) in the past 12 months					66. Impaired use of arms, hands, fingers, legs, feet, or toes <i>(any reason)</i>	
11. Any other ear surgery or procedure including mastoidectomy					67. Joint swelling/inflammation such as arthritis, gout, or bursitis	
12. Loss of balance or vertigo					68. Compartment syndrome, shin splints, or stress reaction/fracture	
13. Hearing loss or use of hearing aid(s)					69. Any surgery of the bone or joint such as placing a screw, plate, rod, pin, prosthetic/graft or arthroscopy	
NOSE, SINUSES, MOUTH, AND LARYNX:			70. Any use of prescribed corrective/prosthetic devices such as a brace, back support, heel lift, or orthotic inserts			
14. Ear, nose, or throat conditions such as vocal cord dysfunction					VASCULAR:	
15. Recurrent nose bleeds, chronic sinus infections, or sinus surgery					71. Abnormal <i>(high or low)</i> blood pressure	
16. Absence of, or disturbance of sense of smell					72. Pale, blue, or numb fingers or toes with exposure to cold such as Raynaud's phenomenon/ disease	
17. Any surgery of the face, throat, or jaw					73. Kawasaki disease	
DENTAL: <i>(If you wear braces/aligners, then you must submit a letter from your orthodontist stating that active orthodontic treatment will be completed before beginning active duty)</i>			SKIN:			
18. Braces or aligners					74. Acne that required prescription medication(s)	
19. Any tooth or gum problems					75. Skin rash such as atopic dermatitis, eczema, or psoriasis	
LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM:			76. Any other skin condition such as recurrent hives, abscesses <i>(hidradenitis)</i> , pilonidal cyst, or cancer <i>(melanoma)</i>			
20. Asthma, asthmatic bronchitis, wheezing, shortness of breath, or other breathing problems worsened by exercise, weather, pollens, etc.					BLOOD AND BLOOD FORMING SYSTEM:	
21. Prescription for an inhaler, steroids, or any other medication for breathing problem					77. Anemia such as iron deficiency, sickle cell, or thalassemia	
22. Pneumonia					78. Blood clot(s), a clotting disorder, or history of taking a blood thinner	
23. Chronic cough or frequent coughing at night					79. Absence or removal of the spleen	
24. Collapsed lung or other lung condition(s)					80. Prolonged bleeding such as after an injury or dental procedure	
25. History of chest, chest wall, or breast surgery					81. Any other blood or circulation condition	
HEART:			SYSTEMIC:			
26. Heart murmur or valve problem(s)					82. Severe allergic reaction to any substance requiring emergency care	
27. Palpitations, skipped/abnormal heartbeats, or pounding heart					83. Tested positive for tuberculosis <i>(skin or blood test)</i> , or lived with someone who had it	
28. Chest pain/pressure or an abnormal electrocardiogram (EKG)					84. Immune system condition such as rheumatoid arthritis, lupus, multiple sclerosis, or AIDS	
29. Heart surgery					85. Sexually transmitted disease such as herpes, syphilis, gonorrhea, chlamydia, or HIV	
30. Any other heart condition					86. Rhabdomyolysis	
ABDOMEN AND GASTROINTESTINAL SYSTEM:			ENDOCRINE AND METABOLIC:			
31. Problems of the stomach, esophagus, or intestine such as ulcer(s)					87. Thyroid conditions such as goiter or hypo/hyperthyroidism	
32. Frequent indigestion/heartburn, difficulty swallowing, or eosinophilic esophagitis					88. Diabetes or hypoglycemia <i>(low blood sugar)</i>	
33. Gallbladder disease or gallstones					89. Any other endocrine <i>(hormone)</i> condition such as growth hormone deficiency, adrenal insufficiency, or hypo/hyperparathyroidism	
34. Hepatitis or jaundice <i>(except neonatal jaundice)</i>					NEUROLOGIC:	
35. Hernia					90. Stroke, aneurysm, or bleeding in or around the brain	
36. Any abdominal surgery/endoscopy such as appendectomy, bowel resection, hernia repair, or colonoscopy					91. Frequent or severe headaches such as migraines, cluster, or tension	
37. Weight loss surgery such as gastric bypass or lap banding					92. A head injury, concussion, or skull fracture	
38. Chronic or recurrent intestinal disease such as irritable bowel syndrome, inflammatory bowel disease, or celiac disease					93. Infection of the brain or spinal cord such as abscess, meningitis, or encephalitis	
39. Anorectal disease, blood from the rectum, or hemorrhoids					94. Seizures, epilepsy, or convulsions	
FEMALES ONLY:			95. Syncope or fainting spells			
40. First day of the last menstrual period (YYYYMMDD)					96. Any other neurologic condition such as paralysis, myasthenia gravis, Tourette's, or memory loss	
41. A change in menstrual pattern <i>(other than pregnancy)</i>					SLEEP:	
42. Pregnancy					97. Sleep apnea	
43. Any abnormal PAP test					98. Sleepwalking, narcolepsy, or difficulty with sleep such as falling/staying asleep	
44. Endometriosis, uterine fibroid, or ovarian cyst					LEARNING, PSYCHIATRIC, AND BEHAVIORAL:	
45. Any other gynecological disorder that required evaluation, treatment, or surgery					99. Attention Deficit or Hyperactivity disorder <i>(ADD/ADHD)</i> , dyslexia, autism spectrum, or other learning disorder	
MALES ONLY:			100. A behavioral/mental health condition such as anxiety/panic attacks, depression, adjustment disorder, PTSD, personality disorder, addiction, or drug/substance abuse including alcohol			
46. Undescended/absent testicle(s), or testicular implant					101. Evaluation or treatment either with medication or counseling for any behavioral/mental health condition	
47. Any scrotal mass, swelling, or pain					102. Eating disorder such as anorexia or bulimia	
48. Prostate problems					103. Self-inflicted injury such as cutting or burning	
URINARY SYSTEM:			104. Suicidal thoughts, gesture, or attempt			
49. Absence of, or a congenital abnormality of a kidney such as horseshoe kidney					105. Admission to a hospital for any behavioral/mental health condition	
50. Blood or protein in urine					TUMORS AND MALIGNANCIES:	
51. Painful or difficult urination					106. Any cancer, malignancy, tumor, or cyst	
52. Kidney stone					MISCELLANEOUS:	
53. Kidney or urinary tract disease, surgery, or infection					107. Cold/heat intolerance or injury such as frostbite or heatstroke	
54. Bedwetting or treatment for bedwetting in the past 12 months					SUPPLEMENTAL QUESTIONS:	
SPINE AND SACROILIAC JOINTS:			108. Prosthetic body part or joint			
55. Back or neck pain, or herniated disc					109. Any medical treatment/surgery from a Hospital, Emergency Room, Surgical Center or Urgent Care	
56. Abnormal curvature of any part of the spine					110. Previous medical disqualification for Military Service	
57. Vertebral fracture or stress injury of the spine such as spondylolysis					111. Discharge from Military Service for any reason <i>(provide reason, date, and type of discharge)</i>	
58. Back or neck surgery					112. Disability award or compensation for an injury or other medical condition	
UPPER EXTREMITIES:						
59. Any pain, swelling, weakness, numbness, or stiffness of the shoulder, elbow, wrist, hand, or fingers						

LAST NAME – FIRST NAME – MIDDLE INITIAL <i>(Suffix)</i>	SOCIAL SECURITY NUMBER	DoD ID NUMBER <i>(If applicable)</i>
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SECTION IV – APPLICANT COMMENTS

Explain all "YES" answers to questions above. Write the item number and provide details to include the following: description of the problem/condition, date of onset of the problem/condition, date of treatment, name of health care provider, clinic, center, hospital along with City and State. Comment on the current status of the problem/condition. Attach additional sheet(s) if necessary, and sign and date each additional sheet. Attach copies of all applicable medical records.

LAST NAME – FIRST NAME – MIDDLE INITIAL <i>(Suffix)</i>	SOCIAL SECURITY NUMBER	DoD ID NUMBER <i>(If applicable)</i>
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SECTION V – MEDICAL PROVIDER SUMMARY

The medical provider will review all applicant comments on "YES" answers, and all submitted supporting medical documentation. The provider will comment below on each "YES" answer. Attach additional sheets if necessary.

CUI (when filled in)

LAST NAME – FIRST NAME – MIDDLE INITIAL <i>(Suffix)</i>				SOCIAL SECURITY NUMBER		DoD ID NUMBER <i>(If applicable)</i>	
SECTION VI - PRESCREEN PROCESSING DETERMINATION							
1.a. MEDICAL PROCESSING STATUS				1.b. REVIEWER INITIALS		1.c. DATE (YYYYMMDD)	
PA	PH	RJ	METR				
KEY: PA = Processing Authorized; PH = Processing Hold; RJ = Return Justified; METR = Medical Evaluation and/or Treatment Records							
2. AUTHORIZING MEDICAL PROVIDER							
a. NAME <i>(Last, First, Middle Initial)</i>				b. SIGNATURE		c. DATE SIGNED (YYYYMMDD)	
						d. NUMBER OF ADDITIONAL SHEETS ATTACHED	
SECTION VII – INTERVIEWING MEDICAL PROVIDER COMMENTS							
3. INTERVIEWING MEDICAL PROVIDER							
a. NAME <i>(Last, First, Middle Initial)</i>				b. SIGNATURE		c. DATE SIGNED (YYYYMMDD)	