

DESRON 15 Separation/Retirement Physical Check List

CDS 15 Cave (BLDG CC 39) located on "Command Hill" across from Human Resources

(Attach to the front of physicals package)

Call Physician Supervisor or CDS15 Medical for assistance at 315-243-5764

PATIENT NAME	LAST 4	PT. CONTACT NUMBER/EMAIL	SHIP/COMMAND

Item #	Purpose (circle <u>all</u> that apply): Separation, Retirement, ADMIN SEP	<u>Item check off</u>
<u>Section 1</u>		
<u>Information for Separation, Retirement and ADMIN SEP physicals</u>		
1	EAOS _____ Date leaving OCONUS _____	
2	If ADMIN SEP - Circle Reason: ex. MH, Misconduct, Substance Abuse, BCA Failures, other _____. Date your pt was identified for ADMIN SEP by your Command: _____ Date of expected separation: _____	
3	If BCA Failure related Admin Sep, has medical w/u for obesity been completed? Circle: Yes or No (Contact DESRON Medical if necessary)	
<u>Section 2</u>		
<u>Required forms</u>		
1	DESRON 15 Medical Separation SF 600- Have patient read/sign and date.	
2	DD 2807 Report of Medical History-Review each line item and addressed each "yes" answer separately (describe all workup/labs/imaging that were done for each complaint, sx's are documented as improving/stable/resolved/worse; status of consults are described, results of labs/imaging/consults are documented).	
3	DD 2808 Report of Medical Examination-I have completed physical exam (in blocks 17-43) and documented (block 44) any findings. (also fill in blocks 45-58 and lab values in block 73).	
4	DD Form 2697 Report of Medical Assessment(for VA)-I have documented all current or active medical conditions from 2807/2808.	
5	NPPSC 1900/1 SEPARATIONS QUESTIONNAIRE. Fill out completely.	
<u>Section 3</u>		
<u>Specific Requirements</u>		
	Current Audiogram with signature on 2808	
	Dental Officer's Signature on 2808 and NPPSC Questionnaire	
	PHA Completed within 1 year. <u>Confirm</u> it is in medical record.	
	PPD results or NAVMED 6224/8 form completed. <u>Confirm</u> in med record.	
	Optometry evaluation with signature within 2 years if patient wears glasses or contacts.	
	Required ancillary services completed/resulted?	
	CBC, UA, HCV AB, HBV AB, LIPIDS, CMP, RPR AND Chest Xray PA-LAT	
	HIV within 2 years	
	Does patient request a Reserves Physical? Circle: Yes/No/NA	
	If female, does pt have WWE complete w/in 1 year? Circle: Yes/No	
	If female, are there any abnormal PAPs in AHLTA? Circle: Yes/No	
	I have reviewed ALL AHLTA previous encounters and ensured all chronic diagnoses and current treatments are described in detail on the 2807.	
	I have <u>not</u> signed in the medical officer signature blocks.	
	I have read the ADDITIONAL GUIDANCE page in detail and understand its content.	

Additional IDC Guidance

-IDCs: ENSURE YOUR PATIENT COMPLETES THEIR SECTION OF THE 2807 CORRECTLY AND FULLY TO SAVE YOU TIME! (each 'yes' answer needs a description by the patient with: **date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status**).

-All blocks that the patient answers yes to on Form 2807 need to be addressed by the IDC on page 2, and must describe the workup performed (ex. imaging/labs/specialty evaluation) and the status of the patient's condition (ex. stable, worsening, improving).

-All conditions for which the patient answers 'yes' that have not been evaluated recently or ever before, and which are not completely resolved, must be evaluated and worked up by the IDC prior to sending the PT to Physician Supervisor— at a minimum all pertinent imaging, labs, EKG, specialty consults should be ordered prior to submitting the package. Contact Physician Supervisor if the patient requires a consult or annotate consult was already submitted.

-YOU are required to check the results of all labs/rad studies that you ordered, and document abnormal results into physicals paperwork. Submit physicals packet for review to Medical ISIC. Contact the office for any other issues.

-Initial all entries you made on the DD 2807 and sign underneath last entry. Do not write "No further Entries". Do not sign in the medical officer signature blocks.

-Patients should be seen between **at least 60-90 days prior to EAOS - and can be seen up to 180 days out from EAOS for Retirees! Sending routine physicals 1 week prior to Separation is UNSAT.**

-**No terminal leave should be authorized by your command until completion of the separation physical.**

-**Once physical is completed, ensure ship's Medical contacts Medical Records at USNH Yokosuka to complete the HAIMS push.**

REPORT OF MEDICAL HISTORY

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

OMB No. 0704-0413
OMB approval expires
Aug 31, 2014

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 1155 Defense Pentagon, Washington, DC 20301-1155 (0704-0413). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, DoD Instruction 6130.03, and E.O. 9397, as amended (SSN).

PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted on the prescreening form (DD 2807-2). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted. Completed forms are covered by recruiting, medical evaluation board, and official military personnel file SORNs maintained by each of the Services.

ROUTINE USE(S): The Blanket Routine Uses found at http://privacy.defense.gov/blanket_uses.shtml apply to this collection.

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. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE (YYYYMMDD)
4.a. HOME ADDRESS (<i>Street, Apartment No., City, State, and ZIP Code</i>)	5. EXAMINING LOCATION AND ADDRESS (<i>Include ZIP Code</i>)	
b. HOME TELEPHONE (<i>Include Area Code</i>)	COMDESRON FIFTEEN MEDICAL PSC 473 BOX 108 FPO AP 96349	

X ALL APPLICABLE BOXES:			7.a. POSITION (<i>Title, Grade, Component</i>)
6.a. SERVICE	6.b. COMPONENT	6.c. PURPOSE OF EXAMINATION	b. USUAL OCCUPATION
<input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	<input type="checkbox"/> Regular <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	<input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (<i>Specify</i>) <input type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program	

8. CURRENT MEDICATIONS (<i>Prescription and Over-the-counter</i>)	9. ALLERGIES (<i>Including insect bites/stings, foods, medicine or other substance</i>)
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Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	12. (Continued)	YES	NO
10.a. Tuberculosis	<input type="radio"/>	<input type="radio"/>	f. Foot trouble (<i>e.g., pain, corns, bunions, etc.</i>)	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input type="radio"/>	i. Knee trouble (<i>e.g., locking, giving out, pain or ligament injury, etc.</i>)	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input type="radio"/>	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input type="radio"/>
f. Bronchitis	<input type="radio"/>	<input type="radio"/>	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="radio"/>	<input type="radio"/>
g. Wheezing or problems with wheezing	<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
h. Been prescribed or used an inhaler	<input type="radio"/>	<input type="radio"/>	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (<i>cracked or fractured</i>)	<input type="radio"/>	<input type="radio"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (<i>liver disease</i>)	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>	e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>	g. Skin diseases (<i>e.g. acne, eczema, psoriasis, etc.</i>)	<input type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (<i>RK, PRK, LASIK, etc.</i>)	<input type="radio"/>	<input type="radio"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow or wrist (<i>e.g. pain, dislocation, etc.</i>)	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (<i>syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.</i>)	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>	c. Currently in good health (<i>If no, explain in Item 29 on Page 2.</i>)	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input type="radio"/>	d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input type="radio"/>

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
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Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO		YES	NO	
15.a. Dizziness or fainting spells	<input type="radio"/>	<input type="radio"/>	19. Have you been refused employment or been unable to hold a job or stay in school because of:			
b. Frequent or severe headache	<input type="radio"/>	<input type="radio"/>		a. Sensitivity to chemicals, dust, sunlight, etc.	<input type="radio"/>	<input type="radio"/>
c. A head injury, memory loss or amnesia	<input type="radio"/>	<input type="radio"/>		b. Inability to perform certain motions	<input type="radio"/>	<input type="radio"/>
d. Paralysis	<input type="radio"/>	<input type="radio"/>		c. Inability to stand, sit, kneel, lie down, etc.	<input type="radio"/>	<input type="radio"/>
e. Seizures, convulsions, epilepsy or fits	<input type="radio"/>	<input type="radio"/>		d. Other medical reasons (If yes, give reasons.)	<input type="radio"/>	<input type="radio"/>
f. Car, train, sea, or air sickness	<input type="radio"/>	<input type="radio"/>		20. Have you ever been treated in an Emergency Room? (If yes, for what?)		
g. A period of unconsciousness or concussion	<input type="radio"/>	<input type="radio"/>				
h. Meningitis, encephalitis, or other neurological problems	<input type="radio"/>	<input type="radio"/>		21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)		
16.a. Rheumatic fever	<input type="radio"/>	<input type="radio"/>	22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.)			
b. Prolonged bleeding (as after an injury or tooth extraction, etc.)	<input type="radio"/>	<input type="radio"/>				
c. Pain or pressure in the chest	<input type="radio"/>	<input type="radio"/>				
d. Palpitation, pounding heart or abnormal heartbeat	<input type="radio"/>	<input type="radio"/>				
e. Heart trouble or murmur	<input type="radio"/>	<input type="radio"/>				
f. High or low blood pressure	<input type="radio"/>	<input type="radio"/>				
17.a. Nervous trouble of any sort (anxiety or panic attacks)	<input type="radio"/>	<input type="radio"/>	23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)			
b. Habitual stammering or stuttering	<input type="radio"/>	<input type="radio"/>				
c. Loss of memory or amnesia, or neurological symptoms	<input type="radio"/>	<input type="radio"/>				
d. Frequent trouble sleeping	<input type="radio"/>	<input type="radio"/>				
e. Received counseling of any type	<input type="radio"/>	<input type="radio"/>				
f. Depression or excessive worry	<input type="radio"/>	<input type="radio"/>				
g. Been evaluated or treated for a mental condition	<input type="radio"/>	<input type="radio"/>				
h. Attempted suicide	<input type="radio"/>	<input type="radio"/>				
i. Used illegal drugs or abused prescription drugs	<input type="radio"/>	<input type="radio"/>				
18. FEMALES ONLY. Have you ever had or do you now have:			24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)			
a. Treatment for a gynecological (female) disorder	<input type="radio"/>	<input type="radio"/>				
b. A change of menstrual pattern	<input type="radio"/>	<input type="radio"/>				
c. Any abnormal PAP smears	<input type="radio"/>	<input type="radio"/>				
d. First day of last menstrual period (YYYYMMDD)	<input type="radio"/>	<input type="radio"/>				
e. Date of last PAP smear (YYYYMMDD)	<input type="radio"/>	<input type="radio"/>	25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.)			
			26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)			
			27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.)			
			28. Have you ever been denied life insurance?			

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

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

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)

SOCIAL SECURITY NUMBER

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*

c. SIGNATURE

d. DATE SIGNED
(YYYYMMDD)

REPORT OF MEDICAL EXAMINATION	1. DATE OF EXAMINATION (YYYYMMDD)	2. SOCIAL SECURITY NUMBER
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PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.
PRINCIPAL PURPOSE(S): 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): None.
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.

3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code)	5. HOME TELEPHONE NUMBER (Include Area Code)
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6. GRADE	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	10.a. RACIAL CATEGORY (X one or more) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White	b. ETHNIC CATEGORY <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino
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11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY b. CIVILIAN	12. AGENCY (Non-Service Members Only)	13. ORGANIZATION UNIT AND UIC/CODE
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14.a. RATING OR SPECIALTY (Aviators Only)	b. TOTAL FLYING TIME	c. LAST SIX MONTHS
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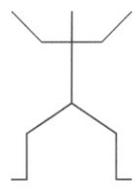
15.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <input type="checkbox"/> Retention <input type="checkbox"/> Dive Duty <input type="checkbox"/> Separation <input type="checkbox"/> SEALs/EOD/SWCC	16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include ZIP Code) DESRON 15 MEDICAL PSC 473 BOX 108 FPO AP 96349
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CLINICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.)

	Nor- mal	Ab- norm	NE
17. Head, face, neck, and scalp			
18. Nose			
19. Sinuses			
20. Mouth and throat			
21. Ears - General (Int. and ext. canals/Auditory acuity under item 71)			
22. Drums (Perforation)			
23. Eyes - General (Visual acuity and refraction under items 61 - 63)			
24. Ophthalmoscopic			
25. Pupils (Equality and reaction)			
26. Ocular motility (Associated parallel movements, nystagmus)			
27. Heart (Thrust, size, rhythm, sounds)			
28. Lungs and chest (Include breasts)			
29. Vascular system (Varicosities, etc.)			
30. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)			
31. Abdomen and viscera (Include hernia)			
32. External genitalia (Genitourinary)			
33. Upper extremities			
34. Lower extremities (Except feet)			
35. Feet (See Item 35 Continued)			
36. Spine, other musculoskeletal			
37. Identifying body marks, scars, tattoos			
38. Skin, lymphatics Skin cancer screen			
39. Neurologic			
40. Psychiatric (Specify any personality deviation)			
41. Pelvic (Females only)			
42. Endocrine			
43. DENTAL DEFECTS AND DISEASE (Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in Item 44.)			
<input type="checkbox"/> Acceptable			
<input type="checkbox"/> Not Acceptable Class _____			

44. NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

#22. TMs mobile VALSALVA Y N



Reflexes (BR, B, P, Ach)

#39. Neuro Exam
 CN II-XII Intact - Y N Symmetric - Y N
 Sensory Intact to Pinprick/Light touch - Y N
 Rapid alternating movements - normal abnormal
 Heel to shin - normal abnormal
 Finger to nose - normal abnormal
 Gait - normal abnormal
 Romberg - negative (normal) positive (abnormal)
 Motor/Strength 5/5 throughout - Y N

35. FEET (Continued) (Circle category)

Normal Arch	Mild	Asymptomatic
Pes Cavus	Moderate	
Pes Planus	Severe	Symptomatic

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
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LABORATORY FINDINGS

45. URINALYSIS	a. Albumin	46. URINE HCG	47. H/H	48. BLOOD TYPE
	b. Sugar			
TESTS	RESULTS	HIV SPECIMEN ID LABEL		DRUG TEST SPECIMEN ID LABEL
49. HIV				
50. DRUGS				
51. ALCOHOL				
52. OTHER				
a. PAP SMEAR				
b.				
c.				

MEASUREMENTS AND OTHER FINDINGS

53. HEIGHT	54. WEIGHT	55. MIN WGT - MAX WGT	MAX BF %	56. TEMPERATURE	57. PULSE		
	lbs.						
58. BLOOD PRESSURE			59. RED/GREEN (Army Only)	60. OTHER VISION TEST			
a. 1ST	b. 2ND	c. 3RD					
SYS.	SYS.	SYS.					
DIAS.	DIAS.	DIAS.					
61. DISTANT VISION		62. REFRACTION BY AUTOREFRACTION OR MANIFEST		63. NEAR VISION			
Right 20/	Corr. to 20/	By	S. CX	Right 20/	Corr. to 20/ by		
Left 20/	Corr. to 20/	By	S. CX	Left 20/	Corr. to 20/ by		
64. HETEROPHORIA (Specify distance)							
ES ^o	EX ^o	R.H.	L.H.	Prism div.	Prism Conv CT NPR PD		
65. ACCOMMODATION		66. COLOR VISION (Test used and result)		67. DEPTH PERCEPTION (Test used and score) AFVT			
Right	Left	PIP /14	Falant /9	Uncorrected	Corrected		
68. FIELD OF VISION			69. NIGHT VISION (Test used and score)		70. INTRAOCULAR TENSION		
					O.D. O.S.		
71a. AUDIOMETER		Unit Serial Number				72a. READING ALOUD TEST	
Date Calibrated (YYYYMMDD)						TEST	
HZ	500	1000	2000	3000	4000	6000	SAT UNSAT
Right							
Left							
71b. Unit Serial Number		Date Calibrated (YYYYMMDD)				72b. VALSALVA	
						SAT UNSAT	
Left							

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY (Use additional sheets if necessary.)

EKG: DATE PERFORMED: _____ RESULTS: _____ PPD: mm Date: _____

PA/LAT: ORDER NUMBER: _____ DATE OF EXAM: _____ RESULTS: _____ Fasting Blood Sugar: _____

HIV Date _____: Results _____

HepC Screen Date _____: Results _____

Blood Type Date _____: Results _____

G6PD Date _____: Results _____

Sickle Cell Date _____: Results _____

HepA #1 Date _____ HepA #2 Date _____

HepB #1 Date _____ HepB#2 Date _____

HepB#3 Date _____

PSA (40+) Date _____: Results _____

Pap (female) Date _____: Results _____

Mammo (female 40+) Date _____: Results _____

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REPORT OF MEDICAL ASSESSMENT

REPORT CONTROL SYMBOL
DD-HA(AR)1939

PRIVACY ACT STATEMENT

AUTHORITY: PL 103-160, EO 9397.

PRINCIPAL PURPOSE: To be used by the Medical Services to provide a comprehensive medical assessment for active and reserve component service members separating or retiring from active duty.

ROUTINE USES: A copy of this form will be released to the Department of Veterans Affairs.

DISCLOSURE: Voluntary; however, failure to disclose the requested personal information may result in delay in processing any disability claim.

SECTION I - TO BE COMPLETED BY SERVICE MEMBER. Any service member who requests a physical examination may have one.

1. NAME (Last, First, Middle)	2. SOCIAL SECURITY NUMBER	3. RANK
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4. COMPONENT	5. UNIT OF ASSIGNMENT
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6a. HOME STREET ADDRESS (Or RFD, including apartment number)	b. CITY	c. STATE	d. ZIP CODE	7. HOME TELEPHONE NUMBER (Include area code)
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8. DATE OF LAST PHYSICAL EXAMINATION BY THE MILITARY (YYMMDD)	9. DATE ENTERED ON CURRENT ACTIVE DUTY (YYMMDD)
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10. COMPARED TO MY LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, MY OVERALL HEALTH IS (X one. If "Worse," explain.)

<input type="checkbox"/>	THE SAME
<input type="checkbox"/>	BETTER
<input type="checkbox"/>	WORSE

11. SINCE YOUR LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, HAVE YOU HAD ANY ILLNESSES OR INJURIES THAT CAUSED YOU TO MISS DUTY FOR LONGER THAN 3 DAYS? (X one. If "Yes," explain.)

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

12. SINCE YOUR LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, HAVE YOU BEEN SEEN BY OR BEEN TREATED BY A HEALTH CARE PROVIDER, ADMITTED TO A HOSPITAL, OR HAD SURGERY? (X one. If "Yes," explain.)

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

13. HAVE YOU SUFFERED FROM ANY INJURY OR ILLNESS WHILE ON ACTIVE DUTY FOR WHICH YOU DID NOT SEEK MEDICAL CARE? (X one. If "Yes," explain.)

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

14. ARE YOU NOW TAKING ANY MEDICATIONS? (X one. If "Yes," list medications.)

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

15. DO YOU HAVE ANY CONDITIONS WHICH CURRENTLY LIMIT YOUR ABILITY TO WORK IN YOUR PRIMARY MILITARY SPECIALTY OR REQUIRE GEOGRAPHIC OR ASSIGNMENT LIMITATIONS? (X one. If "Yes," explain.)

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

16. DO YOU HAVE ANY DENTAL PROBLEMS? (X one. If "Yes," explain.)

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

17. DO YOU HAVE ANY OTHER QUESTIONS OR CONCERN ABOUT YOUR HEALTH? (X one. If "Yes," explain.)

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

18. AT THE PRESENT TIME, DO YOU INTEND TO SEEK DEPARTMENT OF VETERANS AFFAIRS (VA) DISABILITY? (X one. If "Yes," list conditions for which you will ask for VA Disability.)

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

19. CERTIFICATION. I certify that the information provided above is true and complete to the best of my knowledge.

a. SIGNATURE OF SERVICE MEMBER	b. DATE SIGNED
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SECTION II - TO BE COMPLETED BY INDIVIDUALLY PRIVILEGED HEALTH CARE PROVIDER

This Report of Medical Assessment is to be used by the Medical Services to provide a comprehensive medical assessment for active and reserve component service members separating or retiring from active duty. The assessment will cover, as a minimum, the period since the service member's last medical assessment/physical examination, or the period of this call or order to active duty. Any service member who requests a physical examination may have one. Any service member who has indicated "yes" to Item 18 will have an appropriate physical examination, if the last examination is more than 12 months old and/or there are new signs and/or symptoms. If the service member answers "Worse" to Item 10 or "Yes" to Items 11, 12, or 14 through 18, documentation of the injury, illness, or problem should be included in the service member's medical or dental record.

20. HEALTH CARE PROVIDER COMMENTS *(All patient complaints must be addressed)*

21. WAS PATIENT REFERRED FOR FURTHER EVALUATION? *(X one. If "Yes," specify where.)*

- NO
- YES

22. PURPOSE OF ASSESSMENT *(X one. If "Other," explain.)*

- SEPARATION *(Includes discharge from military service and release from active duty, including release of National Guard and Reserve personnel voluntarily or involuntarily called or ordered to active duty.)*
- RETIREMENT
- OTHER

23. MEDICAL FACILITY

24. DATE OF ASSESSMENT
(YYMMDD)

25. HEALTH CARE PROVIDER

- a. NAME *(Last, First, Middle Initial)*
- b. GRADE/RANK
- c. SIGNATURE

NPPSC SEPARATIONS QUESTIONNAIRE
NPPSC 1900/1 (05-2015)

Supporting Directive NPPSCINST 1320.1B CH-2

Privacy Act Statement

AUTHORITY: 10 U.S.C. 5013, Secretary of the Navy.
PURPOSE: To provide necessary separation and contact summary information ensuring final administrative actions are taken when a member separates from the Navy.
ROUTINE USES: Department of Defense employees executing their duties to assist in an individual's separation from the Navy.
DISCLOSURE: Mandatory. Failure to provide the requested information may inhibit the Navy's separation process.

SERVICE MEMBER INFORMATION

1. Rate/Rank		2. Name		3. Date of Birth	
4. Cell Phone Number			5. Personal E-mail Address		
6. Type of Separation				7. Separation Date	
8. Dates of Permissive TDY		9. Dates of Terminal Leave		10. Home of Record	
From:	To:	From:	To:	11. Place of Entry on Active Duty	
				12. Home of Selection (if applicable)	
13. Complete Mailing Address after Separation					
Street Address					
City					
State				Zip Code	
14. Name, Relationship, and Complete Mailing Address of Nearest Relative					
Name					
Relationship					
Street Address					
City					
State				Zip Code	
15. Are You in a Loan Repayment Program?			16. If Yes, State Years of Commitment		
17. Request Copy 6 of DD 214 to the State of			18. Request Copy 3 of DD 214 to be sent to the Central Veteran's Affairs Office in Washington DC		

MEDICAL AND DENTAL ENDORSEMENT

1. Physically Qualified for Separation		2. Dental Exam Complete?	
3. MTF has Possession of the STR?		4. Requires Additional Dental Treatment?	
5. Name of the Medical Treatment Facility			
6. Name of Medical Officer/Representative			
7. Signature of Medical Officer/Representative			
8. Name of Dental Officer/Representative			
9. Signature of Dental Officer/Representative			

Navy members separating from an activity that are not within an area supported by a Navy Medical Treatment Facility (MTF) or do not have DoD MTF within a reasonable commuting distance, please make copies of your service treatment record and dental record and forward the originals to:

NAVY MEDICINE RECORDS ACTIVITY (NMRA)
BUMED DETACHMENT ST LOUIS
4300 GOODFELLOW BLVD BLDG 103
ST LOUIS MO 63120

All service treatment records are the property of the U.S. Government and must be maintained at the appropriate medical/dental facility. The VA cannot process any current or future claim without a complete record on file at the time of separation.

1. Service Member Name		3. CO or Designee Name	
2. Service Member Signature		4. CO or Designee Signature	