

REPORT OF MEDICAL HISTORY

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

Form Approved
OMB No. 0704-0413
Expires *Mar 31, 2010*

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PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397 (SSAN).

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.

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 (Street, Apartment No., City, State, and ZIP Code)	5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)	
b. HOME TELEPHONE (Include Area Code)		

X ALL APPLICABLE BOXES:			7.a. POSITION (Title, Grade, Component)
6.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 (Specify) <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	b. USUAL OCCUPATION

8. CURRENT MEDICATIONS (Prescription and Over-the-counter)	9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)
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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		YES	NO
10.a. Tuberculosis	<input type="radio"/>	<input type="radio"/>	12. (Continued)		
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input type="radio"/>	f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input type="radio"/>	i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="radio"/>	<input type="radio"/>
f. Bronchitis	<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"/>
g. Wheezing or problems with wheezing	<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"/>
h. Been prescribed or used an inhaler	<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<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"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (cracked or fractured)	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>	e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input type="radio"/>	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	<input type="radio"/>	<input type="radio"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input type="radio"/>	c. Currently in good health (If no, explain in Item 29 on Page 2.)	<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
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
<p>15.a. Dizziness or fainting spells</p> <p>b. Frequent or severe headache <input type="radio"/> YES <input type="radio"/> NO</p> <p>c. A head injury, memory loss or amnesia</p> <p>d. Paralysis <input type="radio"/> YES <input type="radio"/> NO</p> <p>e. Seizures, convulsions, epilepsy or fits</p> <p>f. Car, train, sea, or air sickness <input type="radio"/> YES <input type="radio"/> NO</p> <p>g. A period of unconsciousness or concussion</p> <p>h. Meningitis, encephalitis, or other neurological problems <input type="radio"/> YES <input type="radio"/> NO</p>	<p>19. Have you been refused employment or been unable to hold a job or stay in school because of:</p> <p>a. Sensitivity to chemicals, dust, sunlight, etc.</p> <p>b. Inability to perform certain motions <input type="radio"/> YES <input type="radio"/> NO</p> <p>c. Inability to stand, sit, kneel, lie down, etc.</p> <p>d. Other medical reasons (If yes, give reasons.) <input type="radio"/> YES <input type="radio"/> NO</p>
<p>16.a. Rheumatic fever</p> <p>b. Prolonged bleeding (as after an injury or tooth extraction, etc.) <input type="radio"/> YES <input type="radio"/> NO</p> <p>c. Pain or pressure in the chest</p> <p>d. Palpitation, pounding heart or abnormal heartbeat <input type="radio"/> YES <input type="radio"/> NO</p> <p>e. Heart trouble or murmur</p> <p>f. High or low blood pressure <input type="radio"/> YES <input type="radio"/> NO</p>	<p>20. Have you ever been treated in an Emergency Room? (If yes, for what?)</p> <p>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.) <input type="radio"/> YES <input type="radio"/> NO</p> <p>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.)</p>
<p>17.a. Nervous trouble of any sort (anxiety or panic attacks)</p> <p>b. Habitual stammering or stuttering <input type="radio"/> YES <input type="radio"/> NO</p> <p>c. Loss of memory or amnesia, or neurological symptoms</p> <p>d. Frequent trouble sleeping <input type="radio"/> YES <input type="radio"/> NO</p> <p>e. Received counseling of any type</p> <p>f. Depression or excessive worry <input type="radio"/> YES <input type="radio"/> NO</p> <p>g. Been evaluated or treated for a mental condition</p> <p>h. Attempted suicide <input type="radio"/> YES <input type="radio"/> NO</p> <p>i. Used illegal drugs or abused prescription drugs</p>	<p>23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) <input type="radio"/> YES <input type="radio"/> NO</p> <p>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.)</p>
<p>18. FEMALES ONLY. Have you ever had or do you now have:</p> <p>a. Treatment for a gynecological (female) disorder</p> <p>b. A change of menstrual pattern <input type="radio"/> YES <input type="radio"/> NO</p> <p>c. Any abnormal PAP smears</p> <p>d. First day of last menstrual period (YYYYMMDD)</p> <p>e. Date of last PAP smear (YYYYMMDD)</p>	<p>25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.) <input type="radio"/> YES <input type="radio"/> NO</p> <p>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.)</p>
<p>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.) <input type="radio"/> YES <input type="radio"/> NO</p>	<p>28. Have you ever been denied life insurance?</p>
<p>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.)</p>	

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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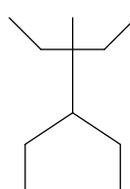
3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)			4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code)				5. HOME TELEPHONE NUMBER (Include Area Code)		
6. GRADE	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	10.a. RACIAL CATEGORY (X one or more) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander			b. ETHNIC CATEGORY <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino		
11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY b. CIVILIAN		12. AGENCY (Non-Service Members Only)			13. ORGANIZATION UNIT AND UIC/CODE				
14.a. RATING OR SPECIALTY (Aviators Only)			b. TOTAL FLYING TIME			c. LAST SIX MONTHS			
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)		

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			
39. Neurologic			
40. Psychiatric (Specify any personality deviation)			
41. Pelvic (Females only)			
42. Endocrine			

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

15c: Dive Duty (Sonar Dome Diver)



#22: TMs mobile to valsalva? Y / N

#39 Neuro Exam:
 CN II-X11 Intact? Y / N
 Sensation to pinprick/light touch? – Y / N
 Rapid alternating movements – Y / N
 Heel to shin – normal / abnormal
 Finger to nose – normal / abnormal
 Gait – normal / abnormal
 Romberg – normal / abnormal
 Motor strength 5/5 throughout – Y / N

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 _____	35. FEET (Continued) (Circle category) <table style="width:100%;"> <tr> <td>Normal Arch</td> <td>Mild</td> <td>Asymptomatic</td> </tr> <tr> <td>Pes Cavus</td> <td>Moderate</td> <td></td> </tr> <tr> <td>Pes Planus</td> <td>Severe</td> <td>Symptomatic</td> </tr> </table>	Normal Arch	Mild	Asymptomatic	Pes Cavus	Moderate		Pes Planus	Severe	Symptomatic
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 lbs.	55. MIN WGT - MAX WGT MAX BF %				56. TEMPERATURE	57. PULSE									
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				71b. Unit Serial Number				72a. READING ALOUD TEST						
Date Calibrated (YYYYMMDD)						Date Calibrated (YYYYMMDD)										
HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000		SAT	UNSAT
Right							Right								72b. VALSALVA	
Left							Left								SAT	UNSAT

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

CXR (PA/LAT) Date _____ Exam # _____ : Results _____

EKG Date _____ : Results _____

PPD Date _____ : Results _____ mm

CBC Date _____ : Hgb _____ Hct _____ WBC _____ Plt _____

UA Date _____ : Glc _____ Bili _____ Ket _____ Blood _____ Prot _____ Nitrite _____ LE _____ WBC _____ RBC _____

Fasting Glc 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 _____

Pap (female) Date _____ : Results _____

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
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74.a. EXAMINEE/APPLICANT (check one)	75. I have been advised of my disqualifying condition.	
<input type="checkbox"/> IS QUALIFIED FOR SERVICE	a. SIGNATURE OF EXAMINEE	b. DATE (YYYYMMDD)
<input type="checkbox"/> IS NOT QUALIFIED FOR SERVICE		

b. PHYSICAL PROFILE								
P	U	L	H	E	S	X	PROFILER INITIALS	DATE (YYYYMMDD)

76. SIGNIFICANT OR DISQUALIFYING DEFECTS									
ITEM NO.	MEDICAL CONDITION/DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE (YYYYMMDD)	QUALIFIED	DIS-QUALIFIED	EXAMINER INITIALS	WAIVER RECEIVED	
								SERVICE	DATE (YYYYMMDD)

77. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers) (Use additional sheets if necessary.)

78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify) (Use additional sheets if necessary.)

79. MEPS WORKLOAD (For MEPS use only)							
WKID	ST	DATE (YYYYMMDD)	INITIAL	WKID	ST	DATE (YYYYMMDD)	INITIAL

80. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	PHYSICIAN'S SIGNATURE

81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE
82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE
83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)	b. SIGNATURE
84.a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY Francis J. Hartge, MD LT MC(UMO/DMO), USN	b. SIGNATURE

85. This examination has been administratively reviewed for completeness and accuracy.		
a. SIGNATURE	b. GRADE	c. DATE (YYYYMMDD)

86. WAIVER GRANTED (If yes, date and by whom)	87. NUMBER OF ATTACHED SHEETS
<input type="checkbox"/> YES	
<input type="checkbox"/> NO	

