

Provider Checksheet

CIRCLE applicable programs below

DIVE/SEALs/SWCC/EOD/MARINE RECON/HAPS/HALO/SONAR DOME

Patient's Name: _____ SSN Last Four: _____

Reference: MANMED 15-5, 15-102, 15-105, AR 40-501 (8-12)

Required Forms:

DD 2807-1 DD 2808 NAVMED 6150/2 NAVPERS 1200/6

Required Studies: Must be within 3 months of Exam

<input type="checkbox"/> CXR (PA/LAT)	<input type="checkbox"/> IOP (If over 40)
<input type="checkbox"/> EKG	<input type="checkbox"/> PSA (If over 40)
<input type="checkbox"/> Audiogram	<input type="checkbox"/> Blood Type (only once in career)
<input type="checkbox"/> Visual Acuity (<u>with Basic Refractive Analysis</u>)	<input type="checkbox"/> Sickle Cell (only once in career)
<input type="checkbox"/> Field of Vision	<input type="checkbox"/> G6PD (only once in career)
<input type="checkbox"/> Depth Perception	<input type="checkbox"/> 2 Doses HEP A Documented
<input type="checkbox"/> Color Vision	<input type="checkbox"/> At least 2 of 3 Doses HEP B Documented
<input type="checkbox"/> Fasting Blood Glucose	<input type="checkbox"/> All Immunizations up to date
<input type="checkbox"/> Fasting Lipid Panel	<input type="checkbox"/> Dental T-2 Exam on DD 2808 (Class 1 or 2)
<input type="checkbox"/> PPD (or QFT Gold if ppd not possible)	<input type="checkbox"/> Stool GUIAC [ONLY for HAPS (HALO)]
<input type="checkbox"/> CBC (WBC, PLT, HGB, HCT)	
<input type="checkbox"/> HEP C Ab	
<input type="checkbox"/> HIV	
<input type="checkbox"/> UA (Must be microscopic and dipstick)	

Physical Exam: Must be performed by physician, PA, or NP

Documented on 2808- Must include skin cancer screen and full neuro. No items shall be NE unless obvious (i.e pelvic exam NE for Male)

All FEMALES must complete the following IN ADDITION to the above*:

PAP Smear within the last 12 months if over age 21.
 Mammogram within the last 12 months starting at age 40 or if at high risk.
*Women's health exam may be transcribed. Does not have to be done again for this exam if it is Current (within 1 year)

Preparer's Name/Rate/Rank: _____

When completed, forward this packet to:

LCDR Edward Utz, UMO
edward.utz@fe.navy.mil
DSN 243-5344

Updated – 22Apr2015

COMSUBGRU 7

Diving/NSW/SO Applicant Medical Examination Worksheet
ALL STUDIES MUST BE WITHIN 3 MONTHS OF PE

1. LAST NAME-FIRST NAME-MIDDLE NAME	Last 4 SSN: 20/
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- _____ 1. Laboratory (Hospital 2nd Deck) **243-5333**
- Give required samples. (Fasting Lipids, Glucose, CBC with diff, UA, Hepatitis C Screening, HIV) **-12 Hour FASTING required!**
 - Blood type, Sickle Cell, G6PD (all only once in career)
 - PSA (if over 40)
- _____ 2. Optometry (Hospital 5th Deck) **243-5352** (Central Appts.)
- IOP (if over 40)

DISTANT VISION		AUTO-REFRACTION			NEAR VISION	
RIGHT 20/	CORR. TO 20/	BY	S.	CX	RIGHT 20/	CORR. TO 20/
LEFT 20/	CORR. TO 20/	BY	S.	CX	LEFT 20/	CORR. TO 20/
COLOR VISION-						
FALANT or OPTEC 900:		/9	/18 (combo of 2 nd and 3 rd trials if any missed on 1 st test)			
Or						
PIP Color Plates:		/14				
TONOMETRY- OD: OS:						
DEPTH PERCEPTION- One of the following						
(1) AFVT:						
(2) Stereo Booklet:						
(3) Verhoeff:		/8	/16 (combo of 2 nd and 3 rd trials if any missed on 1 st test)			

- _____ 3. Radiology (Hospital 1st deck) **243-5534**
- Chest x-ray (PA/LAT)
- _____ 4. Immunizations (Hospital 1st deck) **243-9840**
- Tetanus mandatory, PPD mandatory, and update of Immunizations
 - Other Vaccines: _____ _____ _____
 - All personnel should have 2-doses of Hep A and at least 2 of 3 doses of Hep B
- _____ 5. Family Practice/Internal Medicine for 12-Lead ECG.
Walk-in: 0800-1200/ 1300-1530
- _____ 6. Audiology (Bldg E-22) **243-2607 Walk-in:0800-1130/1300-1500**

Audiometer Serial:	Calibration Date:						
	500	1000	2000	3000	4000	6000	
	512	1024	2048	2896	4096	6144	
RIGHT							
LEFT							

- _____ 7. Dental (NH Yokosuka Dental) **243-8808**
- **Date of Most Recent Dental Exam:** _____ **Class:** _____
 - Exam MUST be current <90 days or Dental Officer MUST perform and sign another exam.

REPORT OF MEDICAL HISTORY

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

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

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 Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0413), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. 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 ADDRESS. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

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)		
<table border="0" style="width:100%;"> <tr> <td style="width:33%; padding: 2px;"> 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 </td> <td style="width:33%; padding: 2px;"> 6.b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard </td> <td style="width:33%; padding: 2px;"> 6.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 </td> </tr> </table>	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	6.b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	6.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	
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	6.b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	6.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			
8. CURRENT MEDICATIONS (Prescription and Over-the-counter)		9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)			

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 (e.g., pain, corns, bunions, etc.)	<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 (e.g., locking, giving out, pain or ligament injury, etc.)	<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) (cracked or fractured)	<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 (liver disease)	<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 (e.g. acne, eczema, psoriasis, etc.)	<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 (RK, PRK, LASIK, etc.)	<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 (e.g. pain, dislocation, etc.)	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<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 (If no, explain in Item 29 on Page 2.)	<input checked="" 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:	<input type="radio"/>	<input type="radio"/>				
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?)	<input type="radio"/>	<input type="radio"/>			
g. A period of unconsciousness or concussion	<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.)	<input type="radio"/>	<input type="radio"/>		
h. Meningitis, encephalitis, or other neurological problems	<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.)		<input type="radio"/>	<input type="radio"/>		
16.a. Rheumatic fever	<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.)			<input type="radio"/>	<input type="radio"/>		
b. Prolonged bleeding (as after an injury or tooth extraction, etc.)	<input type="radio"/>	<input type="radio"/>		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.)		<input type="radio"/>	<input type="radio"/>		
c. Pain or pressure in the chest	<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.)	<input type="radio"/>	<input type="radio"/>	
d. Palpitation, pounding heart or abnormal heartbeat	<input type="radio"/>	<input type="radio"/>					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.)	<input type="radio"/>	<input type="radio"/>
e. Heart trouble or murmur	<input type="radio"/>	<input type="radio"/>			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"/>	<input type="radio"/>
f. High or low blood pressure	<input type="radio"/>	<input type="radio"/>						28. Have you ever been denied life insurance?	<input type="radio"/>
17.a. Nervous trouble of any sort (anxiety or panic attacks)	<input type="radio"/>	<input type="radio"/>	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.)						<input type="radio"/>
b. Habitual stammering or stuttering	<input type="radio"/>	<input type="radio"/>		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.)					<input type="radio"/>
c. Loss of memory or amnesia, or neurological symptoms	<input type="radio"/>	<input type="radio"/>				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.)			<input type="radio"/>
d. Frequent trouble sleeping	<input type="radio"/>	<input type="radio"/>					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.)		<input type="radio"/>
e. Received counseling of any type	<input type="radio"/>	<input type="radio"/>			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.)				<input type="radio"/>
f. Depression or excessive worry	<input type="radio"/>	<input type="radio"/>						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.)	<input type="radio"/>
g. Been evaluated or treated for a mental condition	<input type="radio"/>	<input type="radio"/>	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.)						<input type="radio"/>
h. Attempted suicide	<input type="radio"/>	<input type="radio"/>		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.)					<input type="radio"/>
i. Used illegal drugs or abused prescription drugs	<input type="radio"/>	<input type="radio"/>				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.)			<input type="radio"/>
18. FEMALES ONLY. Have you ever had or do you now have:	<input type="radio"/>	<input type="radio"/>					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.)		<input type="radio"/>
a. Treatment for a gynecological (female) disorder	<input type="radio"/>	<input type="radio"/>			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.)				<input type="radio"/>
b. A change of menstrual pattern	<input type="radio"/>	<input type="radio"/>						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.)	<input type="radio"/>
c. Any abnormal PAP smears	<input type="radio"/>	<input type="radio"/>	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.)						<input type="radio"/>
d. First day of last menstrual period (YYYYMMDD)	<input type="radio"/>	<input type="radio"/>		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.)					<input type="radio"/>
e. Date of last PAP smear (YYYYMMDD)	<input type="radio"/>	<input type="radio"/>				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.)			<input type="radio"/>

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
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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

FAMILY HISTORY:

MI: YES / NO

CAD: YES / NO

STROKE: YES / NO

DM: YES / NO

HTN: YES / NO

CANCER: YES / NO

CHOL: YES / NO

SOCIAL HISTORY:

ALCOHOL USE:

FREQUENCY:

AVG. AMOUNT:

TOBACCO USE: Y / N

TYPE: SMOKELESS/ CIGARETTE/ OTHER

AMOUNT:

NUMBER OF YEARS:

PSYCH HISTORY:

Any psychopharmaceuticals in past year (including smoking cessation aids)? Y / N

Comments on positive answers:

b. TYPED OR PRINTED NAME OF EXAMINER <i>(Last, First, Middle Initial)</i>	c. SIGNATURE	d. DATE SIGNED <i>(YYYYMMDD)</i>
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LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)						SOCIAL SECURITY NUMBER											
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 °		EX °		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		SAT		UNSAT	
Right																	
Left																	
73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY (Use additional sheets if necessary.)																	
EKG: DATE PERFORMED:				PPD: mm Date:				HIV				Date: Results					
RESULTS:								Fasting Blood Sugar:				HepC Screen Date: Results					
PALAT: ORDER NUMBER:												Blood Type Date: Results					
DATE OF EXAM:												G6PD Date: Results					
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					
CBC			UA			LIPIDS											
WBC			COLOR:			CHOL											
HGB			CLARITY:			TRIG											
HCT			SG:			HDL											
PLT			BLOOD:			LDL											
SEG			BIL:			VLDL											
LYM			KETONES														
MONO			GLUC:														
EOS			PROTEIN:														
BASO			PH:														
OTHER			NITRITE:														
			LE:														

HEALTH RECORD

SPECIAL DUTY MEDICAL ABSTRACT

SUMMARY OF PHYSICAL EXAMINATIONS FOR SPECIAL DUTY

DATE	PLACE	PURPOSE	RESULT - RECOMMENDATION (Defects-Waivers)	BUMED ACTION	SIG. OF M.O.
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

SUSPENSION FROM SPECIAL DUTY

DATE (From)	(To)	NO. OF DAYS	REASON FOR SUSPENSION	SIGNATURE OF MEDICAL OFFICER
1.				
2.				
3.				
4.				
5.				
6.				
7.				

PERIODIC SPECIAL DUTY REQUALIFICATION

DATE	SIGNATURE OF MEDICAL OFFICER	DATE	SIGNATURE OF MEDICAL OFFICER	DATE	SIGNATURE OF MEDICAL OFFICER
1.		7.		13.	
2.		8.		14.	
3.		9.		15.	
4.		10.		16.	
5.		11.		17.	
6.		12.		18.	

NAME (Last)	(First)	(Middle)	GRADE/RATE	SERVICE/SSN	ORGANIZATION	AGE
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ALTITUDE TRAINING, AIR COMPRESSION AND OXYGEN TOLERANCE

DATE	STATION	TYPE OF RUN-REACTION	SIG. OF M.O.
1.			
2.			
3.			
4.			
5.			

EXPLOSIVE DECOMPRESSION TRAINING

DATE	STATION	ALTITUDES-REACTION	SIG. OF M.O.
1.			
2.			

SUBMARINE ESCAPE AND DIVING TRAINING

DATE	STATION	TYPE OF RUN-REACTION	SIG. OF M.O.
1.			
2.			
3.			
4.			
5.			

VISUAL AND DISORIENTATION TRAINING

DATE	STATION	TYPE OF TRAINING	SIG. OF M.O.
1.			
2.			
3.			
4.			

CENTRIFUGE AND EJECTION SEAT TRAINING

DATE	STATION	TYPE OF RUN-REACTION	SIG. OF M.O.
1.			
2.			

REMARKS:

U. S. MILITARY DIVING MEDICAL SCREENING QUESTIONNAIRE

Supporting Directives MILPERSMAN 1220-100,
1220-200, 1220-300, and 1200-400

PRIVACY ACT STATEMENT

AUTHORITY AND PURPOSE: 5 U.S.C. 301, Departmental Regulations; and E.O. 9397 (SSN). Provided information is to assist officials and employees of the Navy in management, supervision and administration of Navy personnel (officer and enlisted) and the operations of related personnel affairs and functions.

ROUTING USES: Information will be utilized by Department of the Navy Officials in verifying qualifications for NSW/NSO programs.

1. NAME (Last, First, MI)	2. RATE/RANK	3. DOB
4. PRESENT COMMAND	5. BRANCH OF SERVICE	6. DATE

CONCEALMENT OF MEDICAL HISTORY WILL BE REPORTED TO HIGHER AUTHORITIES
AND MAY RESULT IN PERMANENT DISQUALIFICATION.

DIVING MEDICAL QUESTIONS:

1. Have you ever been found medically disqualified for a dive physical or any other physical at any time?	<input type="radio"/> YES	<input type="radio"/> NO
2. Since your last physical, or in the last 18 months, have you been sick, injured, consulted a physician, used medication (including over-the-counter), or been hospitalized for any reason?	<input type="radio"/> YES	<input type="radio"/> NO
3. Have you ever experienced any middle or inner ear dysfunction including inability to equalize middle ear pressure, inner or middle ear surgery, ringing, disequilibrium, hearing deficit?	<input type="radio"/> YES	<input type="radio"/> NO
4. Is or has your uncorrected vision ever been worse than 20/20 in either eye?	<input type="radio"/> YES	<input type="radio"/> NO
5. Do you have any difficulty distinguishing colors or seeing at night?	<input type="radio"/> YES	<input type="radio"/> NO
6. Have you ever had any corneal surgery, or manipulation to correct poor vision?	<input type="radio"/> YES	<input type="radio"/> NO
7. Since age 12, have you had asthma or wheezing at any time?	<input type="radio"/> YES	<input type="radio"/> NO
8. Have you ever had a collapsed lung (pneumothorax), experienced pulmonary barotrauma, had a positive PPD, or taken INH in the past 6 months?	<input type="radio"/> YES	<input type="radio"/> NO
9. Do you have any skin condition worsened by tight clothing, moisture, or sun exposure?	<input type="radio"/> YES	<input type="radio"/> NO
10. Do you have any musculoskeletal condition that limits intense exercise, suffered any type of fracture in the last 3 months, or had any bone/joint surgery in the last 6 months?	<input type="radio"/> YES	<input type="radio"/> NO
11. Have you ever been evaluated for, or treated for, any psychiatric problems (including depression, anxiety, personality disorder, etc.)?	<input type="radio"/> YES	<input type="radio"/> NO
12. Have you ever had legal, professional or personal problems due to alcohol use, or been diagnosed with dependence, or had any level of treatment for abuse?	<input type="radio"/> YES	<input type="radio"/> NO
13. Have you ever had a migraine or other severe headache?	<input type="radio"/> YES	<input type="radio"/> NO
14. Have you ever had seizures, convulsions or sustained a head injury resulting in loss of consciousness, loss of memory, concussion, or skull fracture?	<input type="radio"/> YES	<input type="radio"/> NO
15. Have you ever had brain surgery?	<input type="radio"/> YES	<input type="radio"/> NO
16. Do you have any area of altered sensation or strength in your body?	<input type="radio"/> YES	<input type="radio"/> NO
17. Have you ever suffered Decompression Sickness or Arterial Gas Embolism?	<input type="radio"/> YES	<input type="radio"/> NO
18. Do you suffer from motion sickness or fear of enclosed spaces?	<input type="radio"/> YES	<input type="radio"/> NO
19. PATIENT SIGNATURE	20. DATE	

U. S. MILITARY MEDICAL SCREENING QUESTIONNAIRE

ANY POSITIVE RESPONSES REQUIRE ELABORATION ON THIS PAGE BY A DIVING MEDICAL OFFICER

1. NAME (Last, First, MI)	2. RATE/RANK	3. DOB
4. PRESENT COMMAND	5. BRANCH OF SERVICE	6. DATE

ADDITIONAL DIVING MEDICAL QUESTIONS:

UMO SCREEN (to be filled out by UMO, HMO or qualified representative)

1. DD Form 2808, Report of Medical Examination and DD Form 2807-1, Report of Medical History are complete, correct, for dive/jump duty and within 1 year of transfer to training?	<input type="radio"/> YES	<input type="radio"/> NO
2. Is the physical signed/countersigned by a UMO or HMO?	<input type="radio"/> YES	<input type="radio"/> NO
3. Every page of member's health record has been reviewed?	<input type="radio"/> YES	<input type="radio"/> NO
4. Any disqualifying condition has a completed, approved waiver from BUMED (Undersea Medicine and Radiation Health)?	<input type="radio"/> YES	<input type="radio"/> NO
5. Any non-disqualifying condition that might affect dive training is thoroughly documented?	<input type="radio"/> YES	<input type="radio"/> NO

UNDERSEA MEDICAL OFFICER COMMENTS

QUESTION #	COMMENT	CD/NCD?		WAIVER?	
		<input type="radio"/> YES	<input type="radio"/> NO	<input type="radio"/> YES	<input type="radio"/> NO
		<input type="radio"/> YES	<input type="radio"/> NO	<input type="radio"/> YES	<input type="radio"/> NO
		<input type="radio"/> YES	<input type="radio"/> NO	<input type="radio"/> YES	<input type="radio"/> NO
		<input type="radio"/> YES	<input type="radio"/> NO	<input type="radio"/> YES	<input type="radio"/> NO
		<input type="radio"/> YES	<input type="radio"/> NO	<input type="radio"/> YES	<input type="radio"/> NO
		<input type="radio"/> YES	<input type="radio"/> NO	<input type="radio"/> YES	<input type="radio"/> NO
		<input type="radio"/> YES	<input type="radio"/> NO	<input type="radio"/> YES	<input type="radio"/> NO
		<input type="radio"/> YES	<input type="radio"/> NO	<input type="radio"/> YES	<input type="radio"/> NO

6. SIGNATURE	7. STAMP
8. PHONE NUMBER	9. FAX NUMBER

RECORD SCREENING (to be filled in by medical department)

10. G6PD Results	11. Sickle Cell Results	12. Blood Type
IMMUNIZATION MUST BE COMPLETED AND CURRENT PRIOR TO TRANSFER	13. Tetanus	14. Typhoid
	15. Yellow Fever	16. HAV
	17. Flu	

U. S. MILITARY MEDICAL SCREENING QUESTIONNAIRE

UMO SCREEN (to be filled out by UMO, HMO or qualified representative)

1. NAME (Last, First, MI)	2. RATE/RANK	3. DOB
4. PRESENT COMMAND	5. BRANCH OF SERVICE	6. DATE

ADDITIONAL DIVING MEDICAL QUESTIONS (continued)

1. PPD given with diving medical examination.	<input type="radio"/> YES	<input type="radio"/> NO	2. DATE	3. PPD Converter	<input type="radio"/> YES	<input type="radio"/> NO
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PPD Converters must complete INH Tx prior to transfer to diver training. PPD annual questionnaire required for converters.

4. Date of last Dive Physical (DD 2807-1/2808):	5. Dental, must be Class I or II. Last examination date:
6. Pressure Test, date completed:	

7. NAVMED 6150/2, Special Duty Medical Abstract required signature from UMO/HMO stating Physically Qualified Diving Duty.	Completed	
	<input type="radio"/> YES	<input type="radio"/> NO
8. The following studies are documented on DD 2808: CXR, EKG, Audiogram, PPD, visual acuity, depth perception, color vision, CBC, urinalysis, and fasting blood glucose?	<input type="radio"/> YES	<input type="radio"/> NO

11. MEDICAL SCREENER NAME, RANK/RATE, AND TITLE	12. PHONE NUMBER
	13. FAX NUMBER

14. COMMAND'S MAILING ADDRESS

NOTE: THE U. S. MILITARY DIVING MEDICAL SCREENING QUESTIONNAIRE MUST BE COMPLETED NO LATER THAN 1 MONTH PRIOR TO ACTUAL TRANSFER TO TRAINING AND PLACED IN THE SERVICE MEMBER'S MEDICAL RECORD. ANY WAIVERS MUST HAVE WRITTEN APPROVAL BY BUREAU OF MEDICINE AND SURGERY (BUMED) AND INCLUDED IN THE SERVICE MEMBER'S MEDICAL RECORD.

DIVING STANDARDS AND WAIVERS:
 NAVMED P-117, Manual of the Medical Department, chapter 15, article 15-102.

BUMED TELEPHONE: COMM (202)762-3444