Flight Duty Medical Examination Coversheet

Exam Date: (DD-MMM-YY) _____

Rank	Last Name	First Name	M.I.	SSN	Age	Type of Physical

DD Form 2808 / DA Form 4497

_____ Blocks 1-15C
_____ CVSP (Phase II, III or IV) Date: _____
_____ Valsalva, Rectal, Guiac
_____ Urine Specimen
_____ ECG
_____ HIV Date: _____
_____ Height/Weight
_____ Pulse
_____ Blood Pressure
_____ Vision
_____ Hearing
_____ Labs
_____ Abdominal Measurement

DD Form 2807-1

_____ Blocks 1-30
_____ Signed Statement / Initials
_____ AMS / Change in History
_____ Answers to All Questions

Tests for Initials

_____ Anthropometry
_____ Cycloplegic
_____ Point of Convergence
_____ Labs Sickle / RPR
_____ RAT
_____ Fear Sticker Signed (CL1)

DD 2992 Issued? Yes No

Expiration: _____

FFD / FFD w/ Waiver / DNIF

Require Optical Devices

2 Glasses: Yes No NA
Glasses needed: 1 2 3
Pro Mask Insert: Yes No NA

DoD PHA	Yes	No
SM Portion		
Record Review		
Provider		

AERO Submit Date:

AERO Qual Check Date:

_____ _____
_____ _____
_____ _____

AERO: _____
AHLTA: _____
JLV: _____
IMR: _____
Profile: _____

Lab Tests:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Administrative Tracking and PKO

Date / Initials

_____ / _____ Lab Results
_____ / _____ Lab Letter Sent
_____ / _____ AERO Entry
_____ / _____ Review
_____ / _____ Final Review
_____ / _____ MEDPros
_____ / _____ HRR
_____ / _____ QA

HOLD: YES / NO

Labs: _____

Consult: Optometry / Repeat Hearing / 3 Day BP

Cardiology / Audiology / BH / Well Woman

Treatment Notes / CVSP Ph II / Colonoscopy

Other: _____

Notes:

DOC SIGN		PA SIGN
_____	2808	_____
_____	4497	_____
_____	2807	_____
_____	EKG	_____
_____	AMS	_____

AMS: _____

FS Initials: _____

Date Submitted: _____

Provider Disposition: Qualified

Disqualified DQ w/ Waiver

Home Phone _____ **Unit Phone** _____ **Cell Phone** _____

Military email address: _____

Name: Date: Physical Type: _____

INTERIM (ABBREVIATED) FLYING DUTY MEDICAL EXAMINATION

For use of this form, see AR 40-501; the proponent agency is OTSG

Exam Date (DD/MMM/YY)

1. SSN	2. NAME *(Last, First, MI)*	3. RANK	4. BIRTH DATE	5. AGE

6. COMPONENT (Check one or more)

☐ AD-RA ☐ AD-USAR ☐ USAR-AGR ☐ USAR-TPU ☐ USAR-IRR
☐ ARNG-AGR ☐ ARNG ☐ DAC ☐ CIV/CONTRACTOR ☐ RETIRED

6b. RACE

☐ White
☐ Black / Afr.Am.
☐ Other

7. Aviation Duty (check one)

☐ CL 2 Pilot ☐ CL 4 ATC
☐ CL 2 FS/APA ☐ CL 4 UAV
☐ CL 3 Crewmember

8. UNIT OF ASSIGNMENT AND COMPLETE UNIT ADDRESS	9. UNIT PHONE	10. HOME PHONE

11. LIST YOUR AEROMEDICAL WAIVERS IN EFFECT (Check box if none)	12. LIST YOUR MEDICATIONS AND DOSAGES (Check box if none)
☐	☐

13. I understand that I must be cleared by a Flight surgeon after hospitalization or sick in quarters, or after treatment or activities that require restrictions; I am informing the flight surgeon of my medical history or any change in my health since my last FDME. I have read AR 600-105 (Aviation Service) and AR 40-8 (Exogenous Factors).

PATIENT'S SIGNATURE

14. EXAM FACILITY ADDRESS

Eastern ARNG Training Site
Bldg 19-109, FTIG
Annville, PA 17003-5004
AEDR Code: 38062

Phone: 717-861-9175

15. BLOOD PRESSURE	16. PULSE	17. HEIGHT	18. WEIGHT	19. % BODY FAT
/	bpm	inches	lbs.	

20. DEPTH PERCEPTION TEST — VTA RANDOT VERHOEFF

b. TEST SCORE

c. TEST RESULT ☐ PASS ☐ FAIL

21. EYE EXAMINATION

	a. DISTANT VISION	b. NEAR VISION	22. IOP
RIGHT	20/ corr to 20/	20/ corr to 20/	mmHg
LEFT	20/ corr to 20/	20/ corr to 20/	mmHg

MANIFEST REFRACTION

BY	S	CX	ADD
BY	S	CX	ADD

24. Abdominal circumference _____ (cm)

Counseled on Tobbacco use: YES / NO

	Yes	No
Cigarettes		
Cigars		
Chew/Snuff		

Class: 2 3 4

26. QUALIFIED / DISQUALIFIED — CONTINUE WAIVERS YES / NO / NA

23. AUDIOMETRIC SCREENING *(Decibles)*

500 Hz	1000	2000	3000	4000	6000

25. EKG Code: P U L H E S

CVSP Ph: 2 / 3 / 4 Date:

Over 40 Screen: GO / NO-GO

Profile Code:

FBS	Chol	Hdl	Trig	Ldl	PSA

UA: Blood, Sugar, Protein: Normal / Abnormal

HCT:

HIV Date Drawn:

This box for USAAMA use only:

FLIGHT SURGEON STAMP AND SIGNATURE

KATHERINE G. MULLIGAN, LTC, MC, FS

AEROMEDICAL PHYSICIAN ASSISTANT STAMP AND SIGNATURE

ARTHUR T HAGELGANS, MAJ, SP, APA-C

REPORT OF MEDICAL EXAMINATION

1. DATE OF EXAMINATION (YYYYMMDD)	2. SOCIAL SECURITY NUMBER

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)
	Work # ( )	

6. GRADE	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX	10.a. RACIAL CATEGORY (X one or more)	b. ETHNIC CATEGORY
			☐ Female ☐ Male	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander	☐ Hispanic/Latino ☐ 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	b. COMPONENT	c. PURPOSE OF EXAMINATION	16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include ZIP Code)
☐ Army ☐ Coast Guard ☐ Navy ☐ Marine Corps ☐ Air Force	☐ Active Duty ☐ Reserve ☐ National Guard	☐ Enlistment ☐ Medical Board ☐ Other ☐ Commission ☐ Retirement ☐ Retention ☐ U.S. Service Academy ☐ Separation ☐ ROTC Scholarship Program	Eastern ARNG Avn Trng Site, Medical Co C/O DMVA, FTIG Annville, PA 17003-5004 #38062 (717) 861-9175 Fax (717) 861-8235

CLINICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.)

	Normal	Abnorm	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.)

22. Valsalva (Bilaterally) NORMAL / ABNORMAL / OMITTED

30. Digital Rectal NORMAL / ABNORMAL / OMITTED

Stool Guaiac NORMAL / ABNORMAL / OMITTED

43. Exam not performed by Dental Officer

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.)

☐ Acceptable

☐ Not Acceptable Class _____

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

LABORATORY FINDINGS

45. URINALYSIS	a. Albumin Pos / Neg	46. URINE HCG	47. H/H	48. BLOOD TYPE
RBC/WBC: Nrm / Abn	b. Sugar Pos / Neg			

TESTS	RESULTS
49. HIV	Date drawn:
50. DRUGS	
51. ALCOHOL	
52. OTHER	
a. PAP SMEAR	NORMAL / ABNORMAL
b. EKG RESULTS	G CODE: _____ WNL / ABN
c. LVH	Yes / No

LABORATORY DATA:
52d.
HCT: _____ (M: 40-52, F: 37-47)
CHOL: _____ (255)
HDL: _____ (M: 40, F: 50)
TRIG: _____ (150)
LDL: _____ (190)
FBS: _____ (110)

ADDITIONAL LABORATORY DATA:
52e.
Sickle: Neg / Pos
RPR: Reactive / Nonreactive
PSA: _____
G6PD: _____ (Normal / Def)
Last CVSP: _____
Date/Phase

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		Cycloplegic Eye Refraction: Corneal Topography: WNL / Abn
SYS.	SYS.	SYS.		OD: Sph _____ Cyl _____ X _____
DIAS.	DIAS.	DIAS.		OS: Sph _____ Cyl _____ X _____

61. DISTANT VISION		62. REFRACTION BY AUTOREFRACTION OR MANIFEST					
Right 20/	Corr. to 20/	Sph	Cyl	X	Right 20/	Corr. to 20/	Add:
Left 20/	Corr. to 20/	Sph	Cyl	X	Left 20/	Corr. to 20/	Add:

64. HETEROPHORIA *(Specify distance)*
ES ° EX ° R.H. L.H. Prism div. Prism Conv CT ortho no tropia / abn NPC _____ mm PD

65. ACCOMMODATION		66. COLOR VISION *(Test used and result)*	67. DEPTH PERCEPTION *(Test used and score)* AFVT / RANDOT	
Right	Left	PIP / RCT PASS / FAIL missed /14	Uncorrected	Corrected

68. FIELD OF VISION	69. NIGHT VISION *(Test used and score)*	70. INTRAOCULAR TENSION	
Normal / Abnormal	NIBH	O.D.	O.S.

71a. AUDIOMETER Unit Serial Number _____ Date Calibrated *(YYYYMMDD)* _____

HZ	500	1000	2000	3000	4000	6000
Right						
Left						

71b. Unit Serial Number _____ Date Calibrated *(YYYYMMDD)* _____

HZ	500	1000	2000	3000	4000	6000
Right						
Left						

72a. READING ALOUD TEST ☐ SAT ☐ UNSAT

72b. AEROMED ADAPT ☐ SAT ☐ UNSAT

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

Abdominal Circumference: _____ cm

Chest X-ray: WNL / Abnormal Date: _____

Anthropometrics:

TAR: _____cm SH: _____cm CH: _____cm

Tobacco Use: Yes / No

Type: _____ How Often: _____ How long: _____

Counseled on Health Risk Associated with Tobacco use: Yes / No

#66. Rabin CCT:

	Red	Green	Blue
Right:	_____	_____	_____
Left:	_____	_____	_____

#67. RANDOT: Missed ____/ 10
_____ sec of arc @ 16 inches
PASS / FAIL

#71a. No changes greater than or equal to 20 dB from baseline audiogram dated: _____

Contrast Sensitivity:
OD: 20/
OS: 20/

"I HAVE NO FEAR OF HEIGHTS, DEPTHS THE DARK OR ENCLOSED SPACES."

Signature: _____

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

74.a. EXAMINEE/APPLICANT *(check one)*

☐ IS QUALIFIED FOR SERVICE

☐ IS NOT QUALIFIED FOR SERVICE

Physical Type: _____

75. I have been advised of my disqualifying condition.

a. SIGNATURE OF EXAMINEE | **b. DATE** *(YYYYMMDD)*

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)*	QUALI-FIED	DIS-QUALI-FIED	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.)*

CLEARED FOR OVER 40 SCREENING: YES / NO FRI:_____% IAW AR 40-501, Chapter 3-14a(5) AS OF DATE OF THIS EXAMINATION.

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
ARTHUR T HAGELGANS, MAJ, SP, APA

b. SIGNATURE

82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER
KATHERINE G. MULLIGAN, LTC, MC, FS

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
KATHERINE G. MULLIGAN, LTC, MC, FS

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)*

☐ **YES**

☐ **NO**

87. NUMBER OF ATTACHED SHEETS

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

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 *(Street, Apartment No., City, State, and ZIP Code)*

b. HOME TELEPHONE *(Include Area Code)*

5. EXAMINING LOCATION AND ADDRESS *(Include ZIP Code)*
Eastern AATS
C/O DMVA, FTIG
Annville, PA 17003
#38062 Phone (717) 861-9175 Fax (717) 861-8235

X ALL APPLICABLE BOXES:

6.a. SERVICE
- ☐ Army
- ☐ Coast Guard
- ☐ Navy
- ☐ Marine Corps
- ☐ Air Force

b. COMPONENT
- ☐ Regular
- ☐ Reserve
- ☐ National Guard

c. PURPOSE OF EXAMINATION
- ☐ Enlistment
- ☐ Commission
- ☐ Retention
- ☐ Separation
- ☐ Medical Board
- ☐ Other *(Specify)*
- ☐ Retirement
- ☐ U.S. Service Academy
- ☐ ROTC Scholarship Program

7.a. POSITION *(Title, Grade, Component)*

b. USUAL OCCUPATION

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
10.a. Tuberculosis	○	○
b. Lived with someone who had tuberculosis	○	○
c. Coughed up blood	○	○
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	○	○
e. Shortness of breath	○	○
f. Bronchitis	○	○
g. Wheezing or problems with wheezing	○	○
h. Been prescribed or used an inhaler	○	○
i. A chronic cough or cough at night	○	○
j. Sinusitis	○	○
k. Hay fever	○	○
l. Chronic or frequent colds	○	○
11.a. Severe tooth or gum trouble	○	○
b. Thyroid trouble or goiter	○	○
c. Eye disorder or trouble	○	○
d. Ear, nose, or throat trouble	○	○
e. Loss of vision in either eye	○	○
f. Worn contact lenses or glasses	○	○
g. A hearing loss or wear a hearing aid	○	○
h. Surgery to correct vision *(RK, PRK, LASIK, etc.)*	○	○
12.a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)*	○	○
b. Arthritis, rheumatism, or bursitis	○	○
c. Recurrent back pain or any back problem	○	○
d. Numbness or tingling	○	○
e. Loss of finger or toe	○	○

12. *(Continued)*	YES	NO
f. Foot trouble *(e.g., pain, corns, bunions, etc.)*	○	○
g. Impaired use of arms, legs, hands, or feet	○	○
h. Swollen or painful joint(s)	○	○
i. Knee trouble *(e.g., locking, giving out, pain or ligament injury, etc.)*	○	○
j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	○	○
k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	○	○
l. Bone, joint, or other deformity	○	○
m. Plate(s), screw(s), rod(s) or pin(s) in any bone	○	○
n. Broken bone(s) *(cracked or fractured)*	○	○
13.a. Frequent indigestion or heartburn	○	○
b. Stomach, liver, intestinal trouble, or ulcer	○	○
c. Gall bladder trouble or gallstones	○	○
d. Jaundice or hepatitis *(liver disease)*	○	○
e. Rupture/hernia	○	○
f. Rectal disease, hemorrhoids or blood from the rectum	○	○
g. Skin diseases *(e.g. acne, eczema, psoriasis, etc.)*	○	○
h. Frequent or painful urination	○	○
i. High or low blood sugar	○	○
j. Kidney stone or blood in urine	○	○
k. Sugar or protein in urine	○	○
l. Sexually transmitted disease *(syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)*	○	○
14.a. Adverse reaction to serum, food, insect stings or medicine	○	○
b. Recent unexplained gain or loss of weight	○	○
c. Currently in good health *(If no, explain in Item 29 on Page 2.)*	○	○
d. Tumor, growth, cyst, or cancer	○	○

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
15.a. Dizziness or fainting spells	○	○
b. Frequent or severe headache	○	○
c. A head injury, memory loss or amnesia	○	○
d. Paralysis	○	○
e. Seizures, convulsions, epilepsy or fits	○	○
f. Car, train, sea, or air sickness	○	○
g. A period of unconsciousness or concussion	○	○
h. Meningitis, encephalitis, or other neurological problems	○	○
16.a. Rheumatic fever	○	○
b. Prolonged bleeding *(as after an injury or tooth extraction, etc.)*	○	○
c. Pain or pressure in the chest	○	○
d. Palpitation, pounding heart or abnormal heartbeat	○	○
e. Heart trouble or murmur	○	○
f. High or low blood pressure	○	○
17.a. Nervous trouble of any sort *(anxiety or panic attacks)*	○	○
b. Habitual stammering or stuttering	○	○
c. Loss of memory or amnesia, or neurological symptoms	○	○
d. Frequent trouble sleeping	○	○
e. Received counseling of any type	○	○
f. Depression or excessive worry	○	○
g. Been evaluated or treated for a mental condition	○	○
h. Attempted suicide	○	○
i. Used illegal drugs or abused prescription drugs	○	○
18. FEMALES ONLY. Have you ever had or do you now have:		
a. Treatment for a gynecological (female) disorder	○	○
b. A change of menstrual pattern	○	○
c. Any abnormal PAP smears	○	○
d. First day of last menstrual period *(YYYYMMDD)*		
e. Date of last PAP smear *(YYYYMMDD)*		

	YES	NO
19. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.	○	○
b. Inability to perform certain motions	○	○
c. Inability to stand, sit, kneel, lie down, etc.	○	○
d. Other medical reasons *(If yes, give reasons.)*	○	○
20. Have you ever been treated in an Emergency Room? *(If yes, for what?)*	○	○
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.)*	○	○
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.)*	○	○
23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	○	○
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.)*	○	○
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.)*

I do / do not have a permanent profile. ____ (initials) I do / do not have a medical waiver. ____ (initials)

The waiver(s) / profile(s) is/are for _____. The waiver has an annual requirement of_____.

"I understand that I must be cleared by a Flight Surgeon after hospitalization or sick in quarters (AR 600-105), and I must inform him after treatment of activities which require restrictions (AR 40-8). I have read AR 40-8, and I have informed the examining physician of any changes in health since the last examination."

_____

Signature of Soldier

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

CAGE Screen: PASS Negative alcohol violations/illegal drugs.

mTBI Screen: Negative headaches, dizziness, fatigue, visual disturbance, or memory problems.

PTSD Screen: Negative nightmares, irritability, easily startled, numb/detached, or sleep problems.

Mental Health Screen:

Over the past month have you wished you were dead or wished you could go to sleep and not wake up? No

In your lifetime have you ever done anything, started to do anything, or prepared to do anything to end your life? No

Have you actually had any thoughts of killing yourself? No

Any current: Negative interpersonal conflicts/social isolation/alcohol or substance abuse/hopelessness/severe agitation/anxiety/depression or other psychiatric disorder /ADD/ADHD/recent loss/financial stress/legal or disciplinary problems/serious physical illness.

Over the past month have you had thoughts or concerns that you might hurt or lose control with someone? No

Interval change since last FDMD dated _____? Denied.

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*

MEDICAL DATA

Date of Visit: _____
(DD - MMM - YY)

SECTION 1 (Please fill all fields)

Name: _____ **Rank:**_____**Grade:**_____

SSN: _____ **DoD ID #:** _____ (Back of CAC Card) **DOB:** _____ (DD - Mon - YY)

Phone: Home: _____ **Work** _____ **Cell:**_____

E-Mail: Official/.mil:_____ **Civilian:**_____

Service: _____ (select one) **Component:** _____ (select one) **Reason for Visit:** _____ (select one)

Sex: _____ (select one) **Organ Donor?** _____ (select one)

SECTION 2 (Physicals Only)

Waiver: _____ (select one) **for** _____ **Profile:** _____ (select one) **for** _____

All completed FDMEs will be accessible in AERO. PAARNG will have their FDME uploaded to HRR.

Home Address:

_____

_____

Unit Name/Address: UIC: _____

_____

_____

Phone:_____

Unit Medical Readiness* POC Name: _____

Phone:_____ **Email:**_____

SECTION 3 (Medical Staff Only)

Reason for Sick Call: _____ **Disposition: Released / Profile / Follow Up / PCM**

Type of Physical: _____ **Date entered into PKO:** _____ **Initials:** _____

AUTHORIZATION FOR THE DISCLOSURE OF MEDICAL INFORMATION

In accordance with the Privacy Act of 1974 (Public Law 93-579), this notice informs you of the purpose of this form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Eastern ARNG Aviation Training Site Medical Company with a means to disclose an individual's protected health information via electronic mail (email).
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for the dissemination of their flight duty medical examination.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information. This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the Eastern ARNG Aviation Training Site Medical Company. I am aware that if I later revoke this authorization, the Eastern ARNG Aviation Training Site Medical Company may have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. If using and authorizing the release of medical records to a civilian email address, I understand that my protected health information may not be encrypted when transmitted via email.
d. have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR 164.524.
e. I request and authorize the Eastern ARNG Aviation Training Site Medical Company to release the information listed below to myself via email and/or the named individual/organization indicated.

(Initials) (Circle One) (All initials and signatures must be completed in ink)

_____ I do / do not authorize the release/dissemination of my flight duty medical examination and associated data to myself via my civilian email.

_____ I do / do not authorize the release/dissemination of my laboratory data and laboratory advisory notices to myself via my civilian email.

_____ I do / do not authorize the release/dissemination of my flight duty medical examination and associated data to a secondary authorized point of contact (POC) listed below via email.

Secondary Authorized POC/email (if applicable): _____

Printed Name: _____ SSN: _____

Signature: _____ Date: _____

LABORATORY REPORT DISPLAY

Eastern ARNG Avn Trng Site **C/O DMVA, FTIG** **ATTN: EAATS-ASB-M** **Annville, PA 17003-5004** **Phone: (717) 861-9175** **Fax: (717) 861-8235**	**LABS ORDERED** (Circle) LIP FBS HIV PSA SIC HgA1C CMP RPR TSH FT3 FT4 CBC OTHER: _____ CPK Uric Acid UA Micro C&S DATE ORDERED: _____ TIME: _____

HCT: _____% F 37 - 47 M 40 - 52

Smoker: Y / N Race: White / Afr. Am. / Oth

** Framingham Risk: _____ ≥ 7.5%

ATTACH

U/A

HERE

METABOLIC SYNDROME

	MALE	FEMALE
ABD: _____	101.5	89
TRIG: _____	≥ 150	
HDL: _____	< 40	< 50
**LDL: _____	≥ 190	
FBS: _____	≥ 110 or DM Rx	
BP: ____ /____	≥ 130 / ≥ 85 or Rx	
**Ratio: _____	≥ 6%	
**Total Chol: _____	≥ 255	

** = Automatic CVSP Ph I Failure

CVSP: PASS / FAIL

NEED REPEAT? YES / NO Date Drawn:_____

Phase II Date: _____ or N/A

REQUESTING PHYSICIAN'S SIGNATURE

NOTES:

NAME: RANK:

SSN: AGE: SEX: _____

DOB: PHONE:

UNIT:

Form Date 17 Jul 19