OSS/FMTS TRACKER INFO SHEET

Date:_____

Sponsor/ Service Member Info

(Please circle) Affiliation: Air Force / Army / Marine Corps / Navy

Sponsor Rank: _____

Last, First MI: _____

Sponsor DODID: _____

Sponsor Full SSN: _____

Dependent Info:

Last, First MI: _____

Last, First MI: _____

Last, First MI: _____

Last, First MI: _____

Last, First MI: _____

Last, First MI: _____

Country Traveling: _____

Projected Duty Station: _____ (ex. Camp Courtney)

EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) QUESTIONNAIRE

Please circle Y (yes) or N (no) to each that apply

Print Name _____ Signature _____

Y/N Does any military dependent have a chronic medical or mental health condition or an educational need requiring access to care or services?

_____ _____

_____ _____

Y/N Does any dependent child have an Individualized Educational Plan (IEP), 504 Plan or speech therapy, or an Individualized Service Plan (IFSP)? If so please list the names.

_____ _____

_____ _____

Y/N Does any military dependent receive treatment for cancer, lupus, heart disease, high/low cholesterol, hypertension, chronic migraines, chronic lower back pain, hyper/hypothyroidism, leukemia, or diabetes? If so please print names.

_____ _____

_____ _____

Y/N Does any military dependent receive treatment for mental/emotional needs, or other long term illnesses? If so print names.

_____ _____

_____ _____

Y/N Are any military dependents diagnosed with any medical condition(s) not listed above?
If so please list the name and condition. Ex. Mr. Lockette (Asthma/allergies etc.)

_____ _____

_____ _____

Y/N Does any military dependent see any type of doctor that ends in *–IST? (Other than gynecologist for routine female needs)* If so please list the name. Ex. Dermatologist, Urologist, Internist, etc.

_____ _____

_____ _____

_____ _____

Staff Signature Date

NMRTC CAMP PENDLETON, CA

OVERSEAS / SUITABILITY SCREENING

MR. DWAYNE LOCKETTE

Schedule Appointment: (760) 719-4853 opt #3 Office Number: (760) 719-4781

Mr.Lockette (760)719-3500/3565

Date Package Received:_____ (Staff Use Only) Date Package Returned:_____

PCS Location:_____ Sponsor DODID:_____ Transfer Date: _____

Name of Dependent:_____ Age:____ Contact Number: _____

(Both Spouse and Service Member)

PLEASE FOLLOW ALL STEPS FOR A TIMELY SCREENING!!

Step 1. Complete ALL Yellow Highlights first.

Step 2. Complete the checked bubbles:

- EFMP Application (DD FORM 2792) if applicable **Bring Copy**
- Education Summary (DD FORM 2792-1) For ALL children Birth – 18 Years of Age
- Dental exam (NAVMED FORM 1300/1 Part II) Completed by sponsor's Dental Clinic **{MILITARY DENTIST ONLY}**
- PAP/Pelvic exam: Required for ages 21 and older, **BRING A COPY OF RESULTS** (Ages 21-30: exam within the last 3 years) (Ages 30-65: exam within the last 5 years)
- Mammogram exam: Required for ages 50 and older, **BRING A COPY OF RESULTS WITHIN THE LAST YEAR**
- If Pregnant or expected to be pregnant, **BRING A LETTER FOR OBGYN STATING HOW MANY WEEKS YOU WILL BE DURING ANTICIPATED TIME OF TRAVEL (NO MORE THAN 30 WEEKS)**

- If seen by a **NON-MILITARY** (Civilian) medical provider, BRING A COPY OF LAST PHYSICAL. (i. e. DETAILED PROGRESS NOTE, WELL CHILD EXAM, WELL BABY EXAM) ****NO AFTER VISIT SUMMARY****
- Vaccine Sheet: Shows the Advisory Committee on Immunizations (ACIP) recommended vaccines. It is encouraged but not mandatory for it to be signed.
- MAKE AND BRING A COPY OF VACCINATION HISTORY (no originals)

Step 3. Make an appointment with your provider (PCM), to complete medical portion of package.

Step 4. Call the appointment line at the top of the package to make the final appointment with Mr. Lockette.

ADVISORY…

- It is advised to not make any plans (airline tickets, household goods shipment etc…) until screening is approved. Screening can take up to 15 business days and sometimes longer after final appointment.
- ***Failure to give disqualifying information may result in administrative punishment.***

****I HAVE BEEN COUNSELED ON THE EFMP REQUIRMENT****

INITIALS:_____ DATE: _____

Patients complete YELLOW Providers complete GREEN

MEDICAL, DENTAL, AND EDUCATIONAL SUITABILITY SCREENING CHECKLIST AND WORKSHEET

Privacy Act Statement: OPNAVINST 1300.14D authorizes collection of this information. The following information and documents, as applicable, are required to conduct medical, dental, and educational screening to determine suitability for an overseas, remote duty, or operational assignment. Complete and current information is essential for completion of screening. Disclosure is voluntary, however, missing or incomplete information may delay the screening process, result in orders held in abeyance until completion of screening, or affect the amount of leave in transit. Refer to BUMEDINST 1300.2B for implementing guidance.

The Suitability Screening Coordinator (SSC) at the military treatment facility (MTF) can assist in obtaining and completing the required information. The SSC will ensure required information and documents are complete and current before referral to a MTF provider for screening and a suitability recommendation. The SSC will place the completed original from in the individual's Service Treatment Record/Non-Service Treatment Record and retain a copy for audit. Medical, dental, and educational suitability screening is valid for 12 months from the date of completion if there were no significant changes in the medical, dental, or educational status of the service or family member. The service member must notify his or her commanding officer or officer in charge of any change in status (including pregnancy).
Complete one form for each Service and family member screened.

SERVICE MEMBER NAME	GRADE/ RATE	SSN

CURRENT UNIT	TELEPHONE NUMBER

NEXT DUTY STATION LOCATION & UNIT IDENTIFICATION CODE (UIC)	TYPE DUTY CLASSIFICATION CODE (Navy Enlisted Code Only)

FAMILY MEMBER NAME	FAMILY MEMBER PREFIX	Age

DO NOT FILL

	ITEM	SSC Review YES	NO	N/A
A. FOR SERVICE MEMBERS:				
☐	1. Legible copy of orders or PCS Overseas Screening Notification. (For operational assignments, orders should indicate the location to which assigned and a description of the duty assignment.)			
☐	2. Each family member's name, family member prefix, social security number, address and telephone number, other than the service member's.			
SERVICE TREATMENT RECORD TO INCLUDE:				
☐	3. All Physical Exams (to include special duty aviation, submarine, radiation, asbestos, etc.) are current and filed in the Service Treatment Record? a. Type of Physical_____ b. Completion Date of Physical _____			
☐	4. Annual Periodic Health Assessment (PHA) current and documented? Date:_____			
☐	5. Current medical history (DD Form 2807-1)			
☐	6. Hearing (Audiogram)			
☐	7. Vision Examination			
☐	8. G-6P-D Test			
☐	9. PPD Test			
☐	10. Sickle Cell Trait Test			
☐	11. Negative HIV results current to 1 year of transfer Date Drawn:_____Roster Number: _____			
☐	12. Blood Type: _____			
☐	13. Pregnancy testing current and documented?			
☐	14. Required immunizations for assignment specific			
☐	15. Military Dental Records			
☐	16. Copies of civilian medical, dental, or mental health care records to include narrative summaries of any inpatient admissions in civilian facilities.			
☐	17. Mammogram current and documented. Date: [redacted]			
☐	18. Pregnancy screen (verbal inquiry). (*Also, command will refer for pregnancy test 30 days prior to departure date.)*			
☐	Other:			
B. FOR FAMILY MEMBERS:				
☐	1. Non-Service Treatment Record (medical and dental) and include a completed DD Form 2807-1			
☐	2. Copies of civilian medical, dental, or mental health care records to include narrative summaries of any inpatient admissions in civilian facilities. Include a completed DD Form 2807-1			

DO NOT FILL

ITEM	SSC Review		
C. FOR DEPENDENT CHILDREN:	YES	NO	N/A
☐ 1. DD FORM 2792-1 (Required for ALL children birth to 22nd Birthday OR High School Graduation)			
FOR INFANTS AND TODDLERS (Birth to 36 Months) ELIGIBLE TO RECEIVE EARLY INTERVENTION SERVICES AS EVIDENCED BY AN INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP):			
☐ 2. Copy of the current IFSP and, if available, developmental assessments or evaluations.			
FOR PRESCHOOL OR SCHOOL-AGE CHILDREN (Ages 3 to 22nd Birthday or High School Graduation) ELIGIBLE TO RECEIVE SPECIAL EDUCATION AND RELATED SERVICES AS EVIDENCED BY AN INDIVIDUALIZED EDUCATION PROGRAM (IEP):			
☐ 3. Copy of the current IEP and, if available, developmental assessments or evaluations.			
FOR EACH FAMILY MEMBER ENROLLED OR UNDERGOING ENROLLMENT IN THE EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP):			
☐ 4. Copy of the DD Form 2792 and any EFMP correspondence.			

D. FOR SSC USE ONLY

1. Date suitability screening conducted. Date: _____

E. SUITABILITY INQUIRY:

☐ 1. Are any of the shaded blocks checked on NAVMED Form 1300/1?
- ☐ YES (Suitability Inquiry required, proceed to question 2)
- ☐ NO (Line through question 2 and proceed to section F)

☐ 2. Suitability Inquiry:

DO NOT FILL

Medical Care: Date & Time sent: Reply date & time:
- ☐ Potential need identified — Sent by (Sending SSC): — Reply from:
- ☐ N/A — Sent to (Gaining SSC): — Contact #:
- E-Mail: _____

Dental Services: Date & Time sent: _____ Reply date & time: _____
- ☐ Potential need identified — Sent by (Sending SSC): _____ Reply from: _____
- ☐ N/A — Sent to (Gaining SSC): _____ Contact #: _____
- E-Mail: _____

Special Education Services: Date & Time sent: _____ Reply date & time: _____
- ☐ Potential need identified — Sent by (Sending SSC): _____ Reply from: _____
- ☐ N/A — Sent to (Gaining SSC): _____ Contact #: _____
- E-Mail: _____

Sent to (Gaining DoDEA): _____ E-Mail: _____

Other information:

DO NOT FILL

F. SUITABILITY SCREENING COORDINATOR: Facility _____

Printed Name: _____	Signature	Date
E-mail: _____		
Phone: _____		

MEDICAL, DENTAL AND EDUCATIONAL SUITABILITY SCREENING FOR SERVICE AND FAMILY MEMBERS

Privacy Act Statement
Authority: 5 U.S.C. 301, Departmental Regulations; and E. O. 9397 (SSN).
Purpose: To identify special, medical, dental or educational needs for the purpose of making a suitability recommendation for an overseas, remote duty, or operational assignment.
Routine uses: This form is completed by a medical treatment facility (MTF)/non-MTF dentist and physician, nurse practitioner, physician assistant, or independent duty corpsman (Service members only). An MTF Medical Screener must counter sign all screenings completed by non-Navy MTF Providers. The MTF Suitability Screening Coordinator (SSC) will place the completed original form in the individual's Service Treatment Record/Non-Service Treatment Record and retain a copy for audit.
Disclosure: Voluntary; however, failure to provide this information may delay the screening process, result in orders held in abeyance until completion of screening or affect the amount of leave in transit.

Refer to BUMEDINST 1300.2B for implementing guidance. ***Complete one form for each Service and family member screened.***

SERVICE MEMBER NAME	GRADE / RATE	AGE	SSN
FAMILY MEMBER NAME	**FAMILY MEMBER PREFIX**	**AGE**	**SSN**
NEXT DUTY STATION LOCATION & UNIT IDENTIFICATION CODE (UIC):		**TYPE DUTY CLASSIFICATION CODE: (Navy enlisted only)**	

PART I

SECTION A. Medical Screening. Completed by the medical provider to identify special needs and determine if a Service or family member is suitable for an overseas, remote duty, or operational assignment. *Attach the completed Report of Medical History (DD 2807-1) to this form.*

Yes	No	N/A	ITEM
✔			1. All current health records (military and civilian) reviewed?
		✔	2. All physical exams (to include special duty, aviation, submarine, radiation, asbestos, etc.) are current and filed in the Service Treatment Record? *a. Type of Physical*_____*b. Completion date of physical*_____
		✔	3. G-6P-D, PPD and Sickle Cell trait test and Blood Type completed & documented?
✔			4a. Immunizations are up-to-date and meet destination country requirements?
	✔		4b. Has the individual elected to decline any ACIP recommended immunizations or country required Immunizations? If yes (circle): ACIP Country Specific Date Counselled: _____
		✔	5. Reference audiogram documented on DD 2215?
		✔	6. Latest audiogram (DD 2216) reviewed?
		✔	7. HIV testing completed or drawn?
		✔	8. DNA testing completed and documented?
		✔	9. Are there pending consults or tests that have a bearing on assignment suitability?
		✔	10. Any past limited duty or medical board(s)? *(document on DD 2807-1)*
			11. For Service members:
			a. Annual periodic health assessment current and documented?
		✔	b. Pregnancy screening (verbal inquiry)? *(Also, Command will refer for pregnancy test 30 days prior to departure date)*
		✔	c. If pregnant? (EDC:_____)
		✔	12. For family members, U.S. Preventive Services Task Force screening test recommendations current and documented?
		✔	13. If a Special Duty assignment, is there a condition, which by MANMED, chapter 15, section IV, is disqualifying?
			14. Are there any conditions requiring ongoing care in the following areas? *(document on DD 2807-1)*
			a. Orthopedic conditions (e.g., chronic back, knee, joint pain or weakness)
			b. Cardiovascular conditions (e.g., chest pain/angina, arrhythmia, valve disease, infarction)
			c. Gynecologic/Urologic conditions (e.g., chronic pelvic pain, abnormal PAP, breast mass)
			d. Neurologic conditions (e.g., seizure, pinched nerve, migraine, neuropathy)
			e. Respiratory conditions (e.g., asthma, RAD, chronic sinus, allergies)
			f. Mental health or behavioral conditions (e.g., mood, personality disorder, ADD/ADHD, anxiety, psychosis, autism)
			g. Recurrent or frequent medications not on the standard formulary or require special attention (e.g., injections/infusions every 6-12 months, medication requiring Risk Evaluation and Mitigation Strategies per FD regulations, hormone replacement therapy, or medications requiring close monitoring of therapeutic blood level)? *(list on DD 2807-1)*
			h. Alcohol or substance abuse or dependence
			i. Developmental concerns (e.g., motor, cognitive, communication, social/emotional, or adaptive development)
			j. Specify other conditions or concerns:
			15. For Service/family members requiring medication.
			a. Does the patient's medication maintenance require a dose adjustment?
			b. Should medication use cease, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior or result in a limited duty, MEDEVAC, or early return situation?
			c. Are there concerns about medication management capabilities at the gaining MTF/operational platform if the underlying condition is exacerbated?
			d. Has the service/family member registered with the mail order pharmacy program through TRICARE?

Yes	No	N/A	ITEM
			16. For service/family members with underlying medical conditions:
			a. Is there a requirement for special medical supplies, adaptive equipment, assistive technology devices, special accommodations, etc.?
			b. If exposed to a physically or emotionally demanding environment, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior, or result in a limited duty or MEDEVAC situation?
			c. Are there any chronic medical or mental health conditions requiring routine or continuing access to care or access to specialized medical care? *(document on DD 2807-1)*
			d. Are there any potential environmental concerns or possible health effects at the gaining location? *(if yes, communicate to family and document on appropriate SF 600)*
			17. For infants and toddlers (birth to 36 months), is the child receiving or undergoing eligibility to receive early intervention services as evidenced by an Individualized Family Service Plan (IFSP)?
			18. For preschool and school age children, is the child receiving or undergoing eligibility to receive special education and/or related services as evidenced by an Individualized Education Program (IEP)?
			19. *Explanation of "yes" responses in shaded boxes (include #):* Are there any concerns about the gaining MTF/operational platform's capabilities to meet the individual's needs? *Specify below:* Navy MTF SSC Name, Signature, Stamp, and Date: _____

Non-Navy Medical Providers: STOP and proceed to SECTION C

SECTION B. Medical and Educational Screening Disposition. Completed by the screening Navy MTF medical provider to determine if a Service or family member is suitable for an overseas, remote duty, or operational assignment.

Yes	No	ITEM
		1. Are any of the above shaded blocks in Section A checked? If "yes", submit a suitability inquiry to the gaining MTF or medical department supporting the overseas/remote duty/operational location to determine local capabilities to provide required support. *(Attach Reply and answer questions 1a and 1b.)* If "no", proceed to question 2.
		a. Does the gaining location have the capabilities to provide the current required medical support?(Service MTFs/TRICARE, etc.)
		b. Does the gaining location have the capabilities to provide the required medical support (diagnostic and therapeutic) if the underlying condition is exacerbated? (To include all Service MTFs/operational platform, TRICARE, etc.)
		2. Is the shaded block of question 18 checked "yes"? If yes, Submit the DD 2792-1 and IEP to the gaining DoDEA Special Education Overseas Screening Coordinator and gaining MTF to determine local capabilities to provide required support. (Attach Reply with POC info and answer question 2a.) If no, proceed to question 3.
		a. Is the DoDEA Special Education Overseas Screening Coordinator recommending travel?

Yes	No	3. IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? *(Must be completed by an MTF medical screener. Answered after the inquiry is completed.)*

SECTION C. Contact Information. Completed by the MTF/non-MTF civilian providers who completed PART I. The Navy MTF medical screener shall review and countersign all suitability screenings completed by non-Navy MTF civilian providers, denoting accountability for a complete and thorough suitability screening document review for each Service/family member.

Navy MTF Medical Screener (Signature) _____ Date _____

Printed Name, Rank or Grade _____

MTF or Duty Station _____

Telephone Number (include area/country code) _____

DSN Number _____

Office Hours to contact _____

E-mail Address _____

Non-Navy MTF/Civilian Medical Screener (Signature) _____ Date _____

Printed Name _____

Address _____

City, State, and Zip Code _____

Telephone Number (include area/country code) _____

Office Hours to Contact _____

E-mail Address _____

PART II

SERVICE / FAMILY MEMBER NAME	GRADE / RATE / FAMILY MEMBER PREFIX	SSN

SECTION A. Dental Screening. Completed by a dental officer/privileged dentist prior to an overseas, remote duty, or operational assignment for the purpose of assessing and matching the dental needs of a service/family member to the support capabilities of the gaining medical treatment facility. **NOTE: If child does not have teeth -AND- is under the age of 24 months, a pediatrician may perform an oral dental screening.**

Yes	No	ITEM
		1. All current dental records (military and civilian) reviewed?
		2. All dental examinations are current? (If more than 180 days since last T-1 or T-2 dental exam, a dental officer/privileged dentist must, at a minimum, review the dental record and interval medical and dental history.)
		3. Is a reexamination required by a Navy MTF if examined or treated at a non-Navy facility?
		4. If service/family member is in Dental Class 3 or 4, can dental treatment or examination be completed before the transfer?
		5. Is there a requirement for follow-on care such as orthodontics, implants, specialty prosthetics, etc.?
		6. Are there any chronic dental conditions requiring routine or continuing access to care or access to specialized dental care?
		7. Are there any concerns about the gaining MTF/operational platform's capabilities to meet the individual's needs? *Specify below:*

Navy MTF SSC Name, Signature, Stamp, and Date: _____

8. Specify Dental Class: *(required for service members)* _____

Dental Classifications: (Per DoDI 6025.19)

Normally considered worldwide deployable:

Class 1 - Patients with a current dental examination, who do not require dental treatment or re-evaluation.

Class 2 - Patients with a current dental examination, who require non-urgent dental treatment or re-evaluation for oral conditions unlikely to result in a dental emergency within 12 months.

Normally not considered worldwide deployable:

Class 3 - Patients who require urgent or emergent dental treatment for oral conditions with a high potential to cause a dental emergency in the next 12 months.

Class 4 - Patients who require a dental examination either because: (1) No type 1 (comprehensive) or type 2 (annual or periodic oral) dental examination was completed by a dental officer/privileged dentist within the past 12 months; (2) A patient's dental record does not exist or; (3) The dental record is not held by the responsible dental treatment facility or Medical Department activity.

SECTION B. Dental Screening Disposition. Completed by the screening MTF provider to determine if a service or family member is suitable for an overseas, remote duty, or operational assignment. **Non-Navy Medical Providers: STOP and proceed to SECTION C.**

Yes	No	ITEM
		1. Are any of the above shaded blocks checked? If yes, submit a suitability inquiry to the gaining MTF or medical department supporting the overseas/remote duty/operational location to determine local dental capabilities to provide required support. *(Attach Reply and answer question 2)* If no, proceed to question 3.
		2. Does the gaining MTF/operational platform have the capabilities to provide the current required dental support?

Yes	No	3. IS THE SERVICE/FAMILY MEMBER SUITABLE FOR THE OVERSEAS, REMOTE DUTY OR OPERATIONAL ASSIGNMENT? *(Must be completed by an MTF dental screener. Answered after the inquiry is completed.)*

SECTION C. Contact Information. Completed by the MTF/non-MTF civilian providers who completed PART II. The Navy MTF dental screener shall review and countersign all suitability screenings completed by non-Navy MTF civilian providers, denoting accountability for a complete and thorough suitability screening document review for each Service/family member.

Navy MTF Dental Screener (Signature) _____ Date _____

Printed Name, Rank or Grade _____

MTF or Duty Station _____

Telephone Number (include area/country code) _____

DSN Number _____

Office Hours to Contact _____

E-mail Address _____

Non-Navy Medical Facility/Civilian Dental Screener (Signature) _____ Date _____

Printed Name _____

Address _____

City, State, and Zip Code _____

Telephone Number (include area/country code) _____

Office Hours to Contact _____

E-mail Address _____

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
September, 30 2021

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, Under Secretary Of Defense For Personnel And Readiness; DoD Directive 1145.2, United States Military Entrance Processing Command; DoD Instruction 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services; and E.O. 9397 (SSN), as amended.
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.
ROUTINE USE(S): The Routine Uses are listed in the applicable system of records notice found at: http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/
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.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2.a. SOCIAL SECURITY NO.	b. DoD ID NO. *(If applicable)*	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)*	
c. EMAIL ADDRESS	

X ALL APPLICABLE BOXES:

6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION	7.a. POSITION *(Title, Grade, Component)*
☐ Army ☐ Coast Guard	☐ Regular	☐ Retention ☐ Other *(Specify)*	
☐ Navy	☐ Reserve	☐ Separation	b. USUAL OCCUPATION
☐ Marine Corps	☐ National Guard	☐ Medical Board	
☐ Air Force		☐ Retirement	

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	DoD ID NUMBER *(If applicable)*

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.)*

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	DoD ID NUMBER *(If applicable)*

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)*

Vaccine Schedule

Vaccine	Birth	1 mo.	2 mo.	4 mo.	6 mo.	12 mo.	15 mo.	18 mo.	19-23 mo	4-6 yrs	7-10 yrs	11-17 yrs	Adult
Hepatitis B	X		X		X								X
Hepatitis A						X				X			X
Rotavirus			X	X	X								
Diphtheria, pertussis, and tetanus			X	X	X		X			X			
Tetanus, diptheria, and pertussis												X	X
Haemophilus influenzae type b			X	X	X	X							
Pneumococcal			X	X	X	X							
Polio vaccine (inactivated)			X	X	X					X			X
Measles, mumps, and rubella						X				X			X
Varicella (chickenpox)						X				X			X
Meningococcus												X	
Human papillomavirus vaccine											X	X	
Influenza					X	X	X	X	X	X	X	X	X

X = required vaccines

Before receiving any vaccines make sure to notify the medical staff if you are pregnant or have allergies.

If you do not have a shot record you will need to get blood work completed in order to know which shot you've already had. (This is called a titer.)

_____ ____ ____ _____

Signature of immunization staff Date