INSTRUCTIONS FOR DD FORM 2807-2, MEDICAL PRESCREEN OF MEDICAL HISTORY REPORT

1. This form is to be completed by each individual who requires medical processing in accordance with Army Regulation 40-501 Chapter 2 standards, or Department of Defense Directive 6130.3, "Physical Standards for Appointment, enlistment, or Induction." The form should be completed by the applicant with the assistance of the recruiter, parent(s), or guardian, as needed (see page 2).

2. Use of this form will also facilitate efficient, timely, and accurate medical processing of individuals applying for service in the United States Armed Forces or Coast Guard. The form is designed to assist recruiters in the medical pre-screening of applicants.

3. The individual completing the DD Form 2807-2 will submit the form, at a minimum, 1 processing day in advance to the MEPS projected to process the individual. A minimum of 2 processing days in advance is required if support documentation (e.g., private physicians paperwork, treatment records, etc.) is required to augment the MEPS CMO review.

EXPLANATION OF CODES.

Items are followed by numbers that refer to the following:

(1) If the applicant has been seen by a physician and/or has been hospitalized for the condition, obtain medical documentation with a medical release form and submit records to the MEPS Medical Section. After the MEPS Medical Officer reviews the provided information, the appropriate recruiting service member will be informed of the examinee's processing status, or if additional record review or specialty consultation may be required for further processing or qualification determination.

a. If the applicant was evaluated and/or treated on an out-patient basis, obtain a copy of actual treatment records of the private medical doctor (PMD) or health care provider (HCP), to include (if any):
- office or clinic assessment and progress notes, including the initial assessment documents, subsequent evaluation and treatment documents, and record and date when released from doctor's care to full, unrestricted activity;
- emergency room (ER) report;
- study reports (e.g., x-ray report(s), magnetic resonance imaging (MRI) report(s), or Computerized Tomography (CT) scan report(s), etc.);
- procedure reports (e.g., arthroscopy, electroencephalogram (EEG; brain wave test), echocardiogram (ultrasound of the heart), etc.);
- pathology reports (e.g., if tissue specimens taken from the body and sent to lab for microscopic diagnosis, etc.);
- specialty consultation records (e.g., neurologist, cardiologist, OB/Gynecologist, gastroenterologist, orthopedic surgeon, pulmonologist, allergist, etc.).

b. If the applicant was hospitalized, then obtain a copy of the hospital record, to include (if any): ER report, admission history and physical, study reports, procedure reports, operative report (especially necessary for surgery to bone or joint), pathology report, specialty consultation reports, and discharge summary.

(2) If an applicant has been diagnosed or treated since age 12 for any attention disorder (Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD), etc.), academic skills or perceptual defect, or has had an Individual Education Plan (IEP), call the MEPS for additional instructions.

(3) Condition to be discussed with the examining Medical Officer at time of the medical examination.

(4) Call MEPS Medical Section to discuss examinee's medical history BEFORE sending the individual in for physical examination.

(5) Send medical reports to MEPS for review before sending applicant for physical ("papers only" medical review), and MEPS Medical Section will advise regarding further medical processing. Records pertaining to non-psychiatric diagnoses may be sent to the Medical Section of the processing MEPS, with the envelope stating: "CONFIDENTIAL: MEPS MEDICAL SECTION."

(6) Send all documentation relating to ANY past or present evaluation, treatment or consultation with a psychiatrist, psychologist, counselor or therapist, on an inpatient or out-patient basis for any reason, including but not limited to counseling or treatment for adjustment or mood disorder, family or marriage problem, depression, treatment or rehabilitation for alcohol, drug or other substance abuse, directly from the treating clinician and/or hospital to the MEPS Chief Medical Officer. The envelope must bear the following statement: "CONFIDENTIAL: FOR EYES OF THE MEDICAL OFFICER ONLY."

(7) May require an orthopedic consult, scheduling to be coordinated by the MEPS CMO and Medical Section.

MEDICAL PRESCREEN OF MEDICAL HISTORY REPORT

(Chapter #2 Physicals Only)

OMB No. 0704-0413
OMB approval expires

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 (SSN).

PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Armed Services. The information collected on this form is used to obtain medical data for a determination of medical fitness for enlistment, induction and applintment of individuals to the Armed Forces.

ROUTINE USE(S): The DoD 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.

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. APPLICANT

a. LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	b. DATE OF BIRTH *(YYYYMMDD)*	c. SOCIAL SECURITY NUMBER

d. HEIGHT	e. WEIGHT	f. MAXIMUM WEIGHT	g. SERVICE/COMPONENT				h. DATE SCREENED *(YYYYMMDD)*
	lbs.		☐ Army ☐ Marine Corps ☐ Coast Guard	☐ Regular	☐ Reserve	☐ National Guard	
			☐ Navy ☐ Air Force				

2. Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 2b.

a. HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
(1) Asthma, wheezing, or inhaler use (4)		
(2) Dislocated joint, including knee, hip, shoulder, elbow, ankle or other joint (1)(7)		
(3) Epilepsy, fits, seizures, or convulsions (4)		
(4) Sleepwalking (4)		
(5) Recurrent neck or back pain (4)(1)(7)		
(6) Rheumatic fever (4)		
(7) Foot pain (3)		
(8) A swollen, painful, or dislocated joint or fluid in a joint *(knee, shoulder, wrist, elbow, etc.)* (1)(7)		
(9) Double vision (4)		
(10) Periods of unconsciousness (4)		
(11) Frequent or severe headaches causing loss of time from work or school or taking medication to prevent frequent or severe headaches (4)		
(12) Wear contact lenses *(If so, bring your contact lens kit and solution so you can remove your contact when we test your vision at the MEPS; also, if you have a pair of eyeglasses, bring them with you no matter how old they are.)*		
(13) Fainting spells or passing out (4)		
(14) Head injury, including skull fracture, resulting in concussion, loss of consciousness, headaches, etc. (4)		
(15) Back surgery (4)		
(16) Seen a psychiatrist, psychologist, social worker, counselor or other professional for any reason *(inpatient or outpatient) including counseling or treatment for school, adjustment, family, marriage or any other problem, to include depression, or treatment for alcohol, drug or substance abuse (6)(2)*		
(17) Any of the following skin diseases:		
(a) Eczema (5)		
(b) Psoriasis (5)		
(c) Atopic dermatitis (5)		
(18) Irregular heartbeat, including abnormally rapid or slow heart rates (4)		
(19) Allergic to bee, wasp, or other insect stings *(itching/swelling all over and/or get short of breath)* (4)		
(20) Heart murmur, valve problem or mitral valve prolapse (4)		
(21) Allergic to wool (4)		
(22) Heart surgery (4)		
(23) Been rejected for military service *(temporary or permanent) for medical or other reasons* (4)		

	YES	NO
(24) Any other heart problems (4)		
(25) High blood pressure (4)		
(26) Discharged from military service for medical reasons (4)		
(27) Ulcer *(stomach, duodenum or other part of intestine)* (4)		
(28) Received disability compensation for an injury or other medical condition (4)		
(29) Hepatitis *(liver infection or inflammation)* (4)		
(30) Intestinal obstruction *(locked bowels)*, or any other chronic or recurrent intestinal problem, including small intestine or colon problems, such as Crohn's disease or colitis (4)		
(31) Detached retina or surgery for a detached retina (4)		
(32) Surgery to remove a portion of the intestine *(other than the appendix)* (4)		
(33) Any other eye condition, injury or surgery (4)		
(34) Are you over 40? *(If so, call the MEPS for information on special requirements for over-40 physicals)* (4)		
(35) Gall bladder trouble or gall stones (4)		
(36) Jaundice (4)		
(37) Missing a kidney (4)		
(38) Allergy to common food *(milk, bread, eggs, meat, fish or other common food)* (4)		
(39) *(Females only)* Abnormal PAP smear or gynecological problem (4)		
(40) *(Males only)* Missing a testicle, testicular implant, or undescended testicle (4)		
(41) Broken bone requiring surgery to repair *(with or without pins, plates, screws or other metal fixation devices used in repair)* (1)(7)		
(42) Ruptured or bulging disk in your back or surgery for a ruptured or bulging disk (4)		
(43) Thyroid condition or take medication for your thyroid (4)		
(44) Limitation of motion of any joint, including knee, shoulder, wrist, elbow, hip or other joint (4)(1)(7)		
(45) Drug or alcohol rehab (4)		
(46) Kidney, urinary tract or bladder problems, surgery, stones or other urinary tract problems (4)		
(47) Sugar, protein or blood in urine (4)		
(48) Surgery on a bone or joint *(knee, shoulder, elbow, wrist, etc.) including Arthroscopy with normal findings* (1)(7)		
(49) Taking any medications *(If so, list reason in Item 2b.)*		

MEDICAL PRESCREEN

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

2a. (Continued) HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO		YES	NO
(50) Pain or swelling at the site of an old fracture (4)(1)(7)			(64) Shoulder, knee, or elbow problem *(out of place)* (4)(1)(7)		
(51) Perforated ear drum or tubes in ear drum(s) (4)			(65) Locking of the knee or other joint (4)(1)(7)		
(52) Anemia (4)			(66) Giving way of knee or other joint (4)(1)(7)		
(53) Ear surgery, to include mastoidectomy or repair of perforated ear drum, hearing loss or need/use a hearing aid (4)			(67) Cataracts or surgery for cataracts (4)		
			(68) Eye surgery, including radial keratotomy, lens implant or other eye surgery to improve your vision (4)		
(54) Night blindness (4)					
(55) Arthritis (4)			(69) Collapsed lung or other lung condition (4)		
(56) Absence or disturbance of the sense of smell (4)			(70) Bed wetting since age 12 (4)		
(57) Absence or removal of the spleen, or rupture or tear of the spleen without removal (4)			(71) Evaluation, treatment, or hospitalization for alcohol abuse, dependence, or addiction (4)(6)		
(58) Anorexia or other eating disorder (4)			(72) Taken medication, drugs, or any substance to improve attention, behavior, or physical performance (2)(1)(6)		
(59) Cracked bone or fracture(s) (4)					
(60) Bursitis (4)			(73) Do you smoke? *(If yes:)*		
(61) Braces *(If you wear or are planning on obtaining braces for your teeth, have the orthodontist submit a letter stating that braces will be removed before active duty date; release form and sample format can be found in the Recruiter's Medical Guide.)*			(a) Type ☐ Cigarettes ☐ Cigars ☐ Smokeless tobacco		
			(b) How many per day? / (c) Date last used		
(62) Loss of finger, toe or part thereof (4)			(74) Evaluation, treatment, or hospitalization for substance use, abuse, addiction or dependence *(including illegal drugs, prescription medications, or other substances)*		
(63) Loss of the ability to fully flex *(bend)* or fully extend a finger, toe or other joint (4)(1)(7)			(75) Any illnesses, surgery, or hospitalization not listed above		

b. EXPLAIN ALL "YES" ANSWERS TO QUESTIONS (1) - (75) ABOVE. *(Describe answer(s), give date(s) of problems, name doctor(s), clinic(s), hospital(s), treatment given and current medical status. Attach additional sheet(s) if necessary.)*

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

b. EXPLAIN ALL "YES" ANSWERS TO QUESTIONS (1) - (74) ABOVE. *(Continued)*

3. CURRENT PRIMARY CARE PHYSICIAN(S)/PRACTITIONER(S) AND/OR CLINIC(S) *(Attach additional sheets if necessary)*

a. NAME(S)	b. ADDRESS *(Include ZIP Code)*	c. TELEPHONE *(Include Area Code)*

4. PREVIOUS PRIMARY CARE PHYSICIAN(S)

a. NAME(S)	b. ADDRESS *(Include ZIP Code)*	c. TELEPHONE *(Include Area Code)*
	DRAFT	

5. CURRENT INSURANCE PROVIDER

a. NAME	b. ADDRESS *(Include ZIP Code)*	c. INSURANCE ID NUMBER

6. PREVIOUS INSURANCE PROVIDER(S)

a. NAME(S)	b. ADDRESS *(Include ZIP Code)*	c. INSURANCE ID NUMBER

STOP AND READ: THE FOLLOWING STATEMENTS APPLY TO SIGNATURES AT ITEMS 7 AND 8

- I certify the information on this form is true and complete to the best of my knowledge and belief, and no person has advised me to conceal or falsify any information about my physical and mental history.
- I further understand that I may be requested to provide medical documentation regarding issues within my medical history.
- I authorize any of the doctors, hospitals, clinics or insurance company(ies) to furnish the Department of Defense medical authority a complete transcript of my medical record for purposes of processing my application for military service.

7. APPLICANT

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*

8. PARENT OR GUARDIAN SIGNATURE FOR MINOR *(Mandatory)* **OR PARENT ASSISTING TO COMPLETE FORM** *(Voluntary)*

a. NAME *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*

9. RECRUITING REPRESENTATIVE: I certify all information is complete and true to the best of my knowledge. I have conducted the medical prescreening requirements as directed by service regulations.

a. NAME *(If representative was used)* *(Last, First, Middle Initial)*	b. PAY GRADE	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*

MEDICAL PRESCREEN

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

10. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician shall comment on all positive answers in questions (1) - (74). Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

DRAFT

11. MEDICAL OFFICER'S PRESCREENING COMMENTS: Based on information provided, further processing is:

a. ON PRESCREEN:

☐ **(1) AUTHORIZED**

☐ **(2) NOT JUSTIFIED** *(Permanent Disqualification (PDQ))*:
- ☐ (a) Profile Serial _____ ICD _____
- ☐ (b) Process for Waiver *(CMO initials)* _____

☐ **(3) DEFERRED** *(See Comments above)*:
- ☐ (a) Pending review of additional documentation
- ☐ (b) RJ Date *(If applicable)* _____ *(CMO initials)* _____

b. ON EXAM:

☐ **(1) APPROVED**

☐ **(2) DEFERRED:/**

☐ **(3) NOT JUSTIFIED:**
- ☐ (a) Additional information needed *(See DD Form 2808)*
- ☐ (b) Information different than on prescreen
- ☐ (c) Form not prescreened by MEPS

(4) MEPS USE:
- ☐ (a) AE
- ☐ (b) RE
- ☐ (c) PRI
- ☐ (d) N/A

c. TYPED OR PRINTED NAME OF EXAMINER	d. SIGNATURE	e. DATE SIGNED *(YYYYMMDD)*	12. NUMBER OF ATTACHED SHEETS

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

13. COMMENTS *(Continued)*