INSTRUCTIONS FOR COMPLETING DD FORM 2807-2, ACCESSIONS MEDICAL HISTORY REPORT

1. This form is to be completed by each individual who requires medical processing in accordance with Department of Defense Instruction (DODI) 6130.03, "Physical Standards for Appointment, Enlistment, or Induction" and DODI 1304.02, "Accession Processing Data Collection Forms." This form must be completed by the applicant with the assistance of the recruiter, parent(s), or guardian, as needed.

2. Replaces the existing medical prescreen form (DD Form 2807-2, MAR 2015) and the DoD Medical Examination Review Board Report of Medical History (DD Form 2492, MAR 2008). Additional questions have been added to improve its usefulness to the accessions medical pre-screening process. The questions are intended to provide the U.S. Military Entrance Processing Command (USMEPCOM) and Department of Defense Medical Examination Review Board (DoDMERB) with health history information necessary to identify conditions commonly related to medical causes for separation during basic and follow-on training (per P.L. 105-85, Div. A, Title V, S 532).

3. Use of medical history information facilitates efficient, timely, and accurate medical processing of individuals applying for Service in the United States Armed Forces or United States Coast Guard. Positive responses do not automatically result in disqualification but are necessary to prompt further explanation that will be used to determine medical qualification. Medical history information assists USMEPCOM/DoDMERB medical personnel in the medical prescreening of applicants. Accurate responses to all questions are critical and all positive responses must be fully explained. Applicant responses to questions may be verified using electronically obtained medical history by the USMEPCOM/DoDMERB. Medical history information will be used by the Department of Defense for continuity of care purposes if and when an applicant accesses into the Armed Forces or Coast Guard. Supporting medical information in the form of historical medical records may also be attached to the Service member's medical record. Medical history information collected by the USMEPCOM/DoDMERB during accession medical processing will serve as the foundation for a Service member's lifecycle electronic medical treatment.

4. If processing at a MEPS: The completed DD Form 2807-2 along with all substantiating and supporting medical documents must be delivered to USMEPCOM for review prior to scheduling the applicant for medical examination. All documents must be submitted for review in accordance with standards below. After review, the Military Entrance Processing Station (MEPS) will notify the Recruiting Service of the applicant's status.

- 1 processing day prior for applicants with no positive medical history (all items marked "NO" with the exception of items 9 (glasses/contacts), 11 (defective color vision), and 20 (braces) which can be "YES").

- 2 processing days prior; for applicants with ANY positive medical history (other than those noted above) and 5 OR LESS single-sided pages of supporting medical documents.

- 3 processing days prior; for applicants with ANY positive medical history (other than those noted above) and MORE THAN 5 single-sided pages of supporting medical documents.

Secure electronic submission is preferable; if not feasible bring/mail to the nearest MEPS which can be found at http://www.mepcom.army.mil/battalions/index.html. All supporting medical documentation must be present with the DD Form 2807-2 to meet the above timeframes for review. After review by a USMEPCOM provider, appropriate processing notification will be made.

5. If processing at a MEPS: If an applicant has been seen by any Health Care Provider (HCP) and/or has been hospitalized for any reason, medical records/documentation must be obtained and submitted along with a medical release to USMEPCOM. Provide all medical documents via secure electronic submission (if possible) to the nearest MEPS. If hand-carried or mailed, ensure they are sealed in an envelope marked: "CONFIDENTIAL: MEPS MEDICAL DEPARTMENT".

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/HCP including:
   (1) office or clinic assessment and progress notes, including the initial assessment documents, subsequent evaluation and treatment documents, and record of date when released from care to full, unrestricted activity;
   (2) emergency room (ER) report(s);
   (3) study reports (e.g. x-ray, magnetic resonance imaging (MRI), Computerized Tomography (CT), etc.);
   (4) procedure reports (e.g., arthroscopy, electroencephalogram (EEG; brain wave test), echocardiogram (ultrasound of the heart), etc.);
   (5) pathology reports (e.g., tissue specimens sent to lab for microscopic diagnosis, abnormal PAP smear cytology, etc.);
   (6) specialty consultation records (e.g., neurologist, cardiologist, OB/GYN, gastroenterologist, orthopedic surgeon, pulmonologist, allergist, etc.).

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

c. If an applicant has been diagnosed or treated for any attention disorder (Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), etc.), academic skills or perceptual defect, or had an Individualized Education Plan or 504 Plan, call/contact the MEPS medical department for additional instructions.

d. Obtain any and all documents relating to any 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 problems, depression, treatment or rehabilitation for alcohol, drug, or substance abuse.

6. MEPS Chief Medical Officers (CMOs) or DoDMERB may locally modify the above instructions and instruct recruiters on what supporting medical documents they require to complete the DD Form 2807-2 medical prescreen review, if doing so enhances the efficiency of medical processing and is consistent with DODI 6130.03 and USMEPCOM/DoDMERB guidance.

7. If all attempts to obtain required substantiating and supporting medical documents fail, the recruiter must contact the appropriate medical department, MEPS medical department for enlistment applicants and DoDMERB for officer applicants, for guidance prior to submitting an incomplete medical prescreen packet.

ACCESSIONS MEDICAL HISTORY REPORT

OMB No. 0704-0413
OMB approval expires

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 504, Persons not qualified; 10 U.S.C. 505, **Regular components: qualifications, term, grade;** 10 U.S.C. 507**, Extension of enlistment for members needing medical care or hospitalization;** 10 U.S.C. 532, Qualifications for original appointment as a commissioned officer; 10 U.S.C. 978, Drug and alcohol abuse and dependency: testing of new entrants; 10 U.S.C. 1201, Regulars and members on active duty for more than 30 days: retirement; 10 U.S.C. 1202, Regulars and members on active duty for more than 30 days: temporary disability retired list; 10 U.S.C. 4346, Cadets: requirements for admission; DoD Directive 1145.2, United States Military Entrance Processing Command; and E.O. 9397 (SSN), as amended.
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): The routine uses are listed in the applicable system of records notice, A0601-270 USMEPCOM DoD, U.S. Military Processing Command Integrated Resources System (USMIRS), located 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. 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 $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 may be subject to prosecution under the Uniform Code of Military Justice or to administrative separation proceedings for discharge, and could receive a less than honorable discharge."

SECTION I - APPLICANT

1. LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	2. AGE	3. DATE OF BIRTH *(YYYYMMDD)*	4.a. SOCIAL SECURITY NUMBER	b. DoD ID NUMBER *(If applicable)*

5. *(X one)* a. SEX (at birth) b. GENDER	6. HEIGHT *(inches)*	7. WEIGHT *(lbs.)*	8.a. SERVICE *(X as applicable)*	b. COMPONENT *(X as applicable)*	3. DATE *(YYYYMMDD)*
☐ Male ☐ Male			☐ Army ☐ USMC	☐ Regular	
☐ Female ☐ Female			☐ Navy ☐ USCG	☐ Reserve Component	
			☐ USAF ☐ Other: _____	☐ National Guard	

10. PURPOSE OF EXAMINATION *(X as applicable)*	11. POSITION *(If a current Federal Employee) (Job Title, Grade, Component)*	12. USUAL OCCUPATION
☐ Enlistment ☐ U.S. Service Academy ☐ Commission ☐ ROTC Scholarship ☐ Retention ☐ Other *(Specify)* _____		

SECTION II - AUTHORIZATION STATEMENT

I (we), the undersigned:

- I Have read and understand the warning and penalties that are associated with providing a false statement.
- 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 Authorize and understand that a physical examination is part of the accession evaluation, may require several visits to the Military Entrance Processing Station (MEPS), and Department of Defense Medical Examination Review Board (DoDMERB) contracted medical centers and that I may have blood work and/or other medical tests, procedures and/or specialty consultations performed as part of my processing. I understand that the results of the examination, tests, and consults will be reviewed and considered as part of my application file and are not performed as part of an individual healthcare treatment plan. The MEPS/DoDMERB medical staff are not my healthcare providers. If I do not receive notice of an abnormal test or consult, I am not to assume that the results are normal. Furthermore, if any test or consult results are abnormal, I am responsible for obtaining those results from the MEPS and for any necessary follow-up evaluations and/or treatment. If I am notified to return to the MEPS to discuss medical results, it is my responsibility to take quick action to return to the MEPS to speak with the Chief Medical Officer (CMO). Any concerns that I have about my health and healthcare are my responsibility to address with my personal healthcare provider(s).
- I Understand that neither USMEPCOM or DoDMERB are financially responsible for costs associated with any necessary follow-up evaluations and/or treatment based on my screening evaluation. Any concerns that I have about my health and healthcare are my responsibility to address with my personal healthcare provider(s)
- I Understand that I must provide required documentation regarding my health history which, upon my accession, will become part of my Service member lifecycle medical treatment record.
- I I agree that all personal information or data disclosed by myself or others on my behalf with my consent during this process may be further disseminated as needed during the accession process and that my medical information is no longer protected by federal Health Insurance Portability and Accountability Act of 1966 (HIPAA) Privacy Regulations.
- I Authorize release of records and information relating to grades, performance, individual education plans, and disciplinary proceedings. Under the Family Educational Rights and Privacy Act (FERPA) USMEPCOM/ DoDMERB is authorized to receive all my education/disciplinary records for evaluation of my acceptability for Service in the Armed Forces.
- I Understand that I have the right to refuse to sign this authorization but also understand that failure to do so may cause me to be found disqualified for further processing.
- I Understand this authorization will expire four years from the date of the signature below or sooner if written request is received by USMEPCOM/DoDMERB Staff Judge Advocate's Office. I have the right to revoke this authorization in writing, except to the extent that the DoD has acted in reliance on this information.

1. APPLICANT

a. Signature	b. Date Signed *(YYYYMMDD)*

2. PARENT OR GUARDIAN SIGNATURE IS MANDATORY FOR MINOR APPLICANT, SIGNATURE IS OPTIONAL IF APPLICANT IS OF AGE

a. Name *(Last, First, Middle Initial)*	b. Signature	c. Date Signed *(YYYYMMDD)*

3. RECRUITING REPRESENTATIVE: *(If a representative was used)* **I certify all information is complete and true to the best of my knowledge.**

a. Name *(Last, First, Middle Initial)*	b. Recruiter Identification Number	c. Signature	d. Date Signed *(YYYYMMDD)*

SECTION III - MEDICAL HISTORY. Check each item "Yes" or "No". All "Yes" items must be fully explained in Section IV, Page 5.

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
EYES		
1. Double vision	☐	☐
2. Detached retina or surgery to repair a detached retina	☐	☐
3. Cataracts or surgery for cataracts	☐	☐

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
EYES *(Continued)*		
4. Eye surgery to improve vision (RK, PRK, LASIK, etc.)	☐	☐
5. Night blindness	☐	☐
6. Glaucoma	☐	☐

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*	DoD ID NUMBER *(If applicable)*

SECTION III - MEDICAL HISTORY *(Continued)*. Check each item "Yes" or "No". All "Yes" items must be fully explained in Section IV, Page 5.

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
7. Strabismus or "lazy eye" or any surgery to correct these		
8. Any other eye condition, injury or surgery		
VISION		
9. Worn/wear contact lenses or glasses (Bring your contact lens kit and solution so you can remove contacts during vision testing, or for best results remove 72 hours prior. Bring your eyeglasses no matter how old they are.)		
10. Loss of vision in either eye		
11. Color vision deficiency or color blindness		
EARS		
12. Perforated ear drum or tubes in ear drum(s)		
13. Ear surgery, to include mastoidectomy or repair of perforated ear drum		
14. Loss of balance or vertigo		
HEARING		
15. Hearing loss or wear a hearing aid		
NOSE, SINUSES, MOUTH, AND LARYNX		
16. Ear, nose, or throat trouble including tonsillectomy		
17. Chronic sinus infections or recurrent nose bleeds		
18. Absence of, or disturbance of sense of smell		
19. Any surgery of your face, mandible or jaw		
DENTAL		
20. Do you wear dental braces or plan to wear braces? (If so, your orthodontist must submit a letter stating that active orthodontic treatment will be completed prior to active duty date: release form/sample format can be found in the Recruiter's Medical Guide.)		
21. Tooth or gum problems (other than cavities)		
LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM		
22. Asthma		
23. Wheezing		
24. Shortness of breath		
25. Bronchitis		
26. Other breathing problems worsened by exercise, weather, pollens, etc.		
27. Used inhaler(s) or steroids for breathing problem(s)		
28. Chronic cough or frequent coughing at night		
29. Collapsed lung or other lung condition		
30. History of chest, chest wall, or breast surgery		
HEART		
31. Heart murmur, valve problem or mitral valve prolapse		
32. Palpitation, pounding heart or abnormal heartbeat		
33. Heart surgery		
34. Pain or pressure in the chest		
35. An abnormal electrocardiogram (EKG)		
36. Any other heart problems		
ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM		
37. Stomach, esophageal or intestinal ulcer		
38. Difficulty swallowing		
39. Frequent indigestion or heartburn		
40. Gall bladder trouble or gallstones		
41. Jaundice (except neonatal) or hepatitis (liver disease)		
42. Rupture/hernia		
43. Surgery to remove or repair a portion of the intestine or spleen (other than the appendix)		
44. Chronic or recurrent intestinal problem of the small or large bowel such as Irritable Bowel Syndrome, Crohn's disease, Ulcerative Colitis, or Celiac disease		
45. Rectal disease, hemorrhoids, or blood from the rectum		
46. Hemorrhoid surgery		
47. Bariatric surgery (weight loss surgery)		

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
FEMALES ONLY:		
48. A change of menstrual pattern (other than pregnancy)		
49. Pregnancy, abortion or miscarriage		
50. Any abnormal PAP smear(s)		
51. Date of last PAP smear *(YYYYMMDD)*		
52. Diagnosed with endometriosis or ovarian cysts		
53. Evaluation, treatment or surgery for any other gynecological (female) disorder		
54. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)		
55. First day of last menstrual period *(YYYYMMDD)*		
56. Missing a testicle, testicular implant, or undescended testicle		
57. Varicocele, hydrocele, or any scrotal mass, swelling or pain		
58. Prostate problems		
59. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)		
URINARY SYSTEM		
60. Missing a kidney		
61. Kidney stone, infection or disease		
62. Kidney or urinary tract surgery of any kind		
63. Blood or protein in urine		
64. Painful or difficult urination		
65. Bedwetting or treatment for bedwetting (previous 12 months)		
66. Hernia		
SPINE AND SACROILIAC JOINTS		
67. Back pain or back problem		
68. Herniated disk		
69. Neck pain		
70. Back or neck surgery		
71. Abnormal curvature of your spine (any part)		
UPPER EXTREMITIES		
72. Painful shoulder, elbow, wrist, hand or fingers		
73. Dislocated shoulder, elbow, wrist, hand or fingers		
LOWER EXTREMITIES		
74. Foot trouble (e.g., pain, corns, bunions, warts, ingrown toenails, etc.)		
75. Knee trouble (e.g., locking, giving out, or ligament injury, etc.)		
76. Painful hip, knee, ankle, foot or toes		
77. Dislocated hip, knee, ankle, foot or toes		
MISCELLANEOUS CONDITIONS OF THE EXTREMITIES		
78. Bone, joint, or other orthopedic deformity		
79. Loss of finger or toe, or extra finger or toe		
80. Loss of the ability to fully flex (bend) or fully extend a finger, toe, or other joint		
81. Impaired use of arms, hands, legs, or feet (any reason)		
82. Arthritis, rheumatism, gout, or bursitis		
83. Any swollen joint(s)		
84. Surgery on any joint/bone (including arthroscopy)		
85. Plate(s), screw(s), rod(s) or pin(s) in any bone		
86. Pain or swelling at the site of an old fracture		
87. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics		
88. Any other orthopedic, muscle, or sports injury problems		
VASCULAR		
89. High or low blood pressure		
90. Raynaud's phenomenon or disease		
91. Deep Vein Thrombosis (blood clot; leg or elsewhere)		
92. Pulmonary embolism (blood clot in lung)		

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*	DoD ID NUMBER *(If applicable)*

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
SKIN AND CELLUAR		
93. Acne	☐	☐
94. Atopic dermatitis or Eczema	☐	☐
95. Psoriasis	☐	☐
96. Large or painful scars	☐	☐
97. Any other skin problems	☐	☐
BLOOD AND BLOOD FORMING TISSUES		
98. Anemia (iron deficiency, sickle cell, thalassemia)	☐	☐
99. Blood clots requiring blood thinner medicine	☐	☐
100. Absence or removal of the spleen	☐	☐
101. Prolonged bleeding (after an injury or tooth extraction)	☐	☐
102. Any other blood or circulation problems	☐	☐
SYSTEMIC		
103. Adverse reaction to medication (describe reaction in Section IV)	☐	☐
104. Adverse reaction to serum, insect bites, or stings	☐	☐
105. Allergy to foods (milk, eggs, fish, meat, nuts, etc.)	☐	☐
106. Allergy to wool, latex, or other material	☐	☐
107. Tuberculosis or lived with someone who had tuberculosis	☐	☐
108. Positive test for tuberculosis (PPD or blood test)	☐	☐
109. Malaria	☐	☐
110. Disorder(s) of your immune system (including HIV)	☐	☐
111. Car, train, sea, or air sickness	☐	☐
ENDOCRINE AND METABOLIC		
112. Thyroid trouble or goiter	☐	☐
113. High or low blood sugar	☐	☐
114. Diabetes or told that you should be tested for diabetes	☐	☐
NEUROLOGIC		
115. Cerebrovascular incident (stroke)	☐	☐
116. Frequent or severe headaches, including migraines	☐	☐
117. Taking medication to prevent headaches	☐	☐
118. Lost time from work or school due to frequent or severe headaches	☐	☐
119. A skull fracture	☐	☐
120. A head injury, memory loss, or amnesia	☐	☐
121. A period of unconsciousness or concussion	☐	☐
122. Loss of memory or amnesia, or neurological symptoms	☐	☐
123. Paralysis	☐	☐
124. Meningitis, encephalitis, or other neurological problems	☐	☐
125. Seizures, convulsions, epilepsy or fits	☐	☐
126. Dizziness or fainting spells	☐	☐
127. Any other neurologic problems	☐	☐
SLEEP DISORDERS		
128. Sleepwalking or narcolepsy	☐	☐
129. Frequent trouble sleeping	☐	☐
130. Sleep apnea or severe snoring	☐	☐
LEARNING, PSYCHIATRIC, AND BEHAVIORAL		
131. Evaluated or treated for Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)	☐	☐
132. Taken (or taking) medication, drugs, or any substance to improve attention, behavior, or physical performance	☐	☐
133. Diagnosed with a learning disorder, to include dyslexia	☐	☐
134. Received counseling of any type	☐	☐
135. Seen a psychiatrist, psychologist, social worker, counselor or other professional for any reason (inpatient or out-patient) including counseling or treatment for school, adjustment, family, marriage, divorce, depression, anxiety, or treatment of alcohol, drug or substance abuse (Applicant or recruiter will request sealed medical supporting documents from health care providers marked "CONFIDENTIAL: MEPS MEDICAL DEPARTMENT" and submit directly to MEPS medical personnel.)	☐	☐

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
LEARNING, PSYCHIATRIC, AND BEHAVIORAL *(Continued)*		
136. Been expelled or suspended from school	☐	☐
137. Been kicked out or removed from your home	☐	☐
138. Been arrested or other encounters with law enforcement	☐	☐
139. Been evaluated or treated, either with medication or counseling, for a mental condition, depression or excessive worry	☐	☐
140. Nervous trouble of any sort (anxiety or panic attacks)	☐	☐
141. Anorexia, bulimia, or other eating disorder	☐	☐
142. Habitual stammering or stuttering	☐	☐
143. Have you ever purposely cut or harmed yourself	☐	☐
144. Have you ever attempted or considered suicide	☐	☐
145. Used illegal drugs or abused prescription drugs	☐	☐
146. Have you been evaluated, treated, or hospitalized for substance abuse, addiction or dependence (including illegal drugs, prescription medications or other substances)	☐	☐
147. Have you been evaluated, treated, or hospitalized for alcohol abuse, dependence, or addiction	☐	☐
148. Post-traumatic Stress Disorder or excessive stress requiring counseling and/or medication following a traumatic experience	☐	☐
149. Any other learning, psychiatric, or behavioral problems	☐	☐
TUMORS AND MALIGNANCIES		
150. Tumor, growth, cyst, or cancer of any type	☐	☐
MISCELLANEOUS		
151. Cold injury, frostbite or cold intolerance	☐	☐
152. Heat injury, heat stroke or heat intolerance	☐	☐
SUPPLEMENTAL QUESTIONS		
153. Are you taking any medications, to include over the counter medications (OTCs), vitamin, herbal, or nutritional supplements (If "yes", list all in Section IV.)	☐	☐
154. Any recent unexplained gain or loss of weight	☐	☐
155. Artificial or replacement body part (eye, bone, palate, hip, knee, joint, leg, arm, etc.)	☐	☐
156. Have you ever had any illness or injury other than those already noted? (If "yes", specify when, where and give details in Section IV.)	☐	☐
157. Have you ever been treated in an Emergency Room? (If "yes", explain in Section IV.)	☐	☐
158. Have you ever been a patient in any type of hospital (including being kept overnight)? (If "yes", specify when, where, why, and name of doctor and complete address of hospital in Section IV.)	☐	☐
159. Have you ever had, or have you been advised to have any operations or surgery? (If "yes", describe and give age at which occurred in Section IV.)	☐	☐
160. Have you ever been rejected for military Service for any reason? (If "yes", give date and reason in Section IV.)	☐	☐
161. Have you ever been discharged from the military Service for any reason? (If "yes", give date, reason, and type of discharge, whether honorable, other than honorable, for unfitness or unsuitability in Section IV.)	☐	☐
162. Have you ever been refused employment or been unable to hold a job or stay in school because of any of the following: (If "yes", answer a - d below and give reasons in Section IV.)	☐	☐
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	☐	☐
163. Applied for and/or received disability evaluation and/or compensation for an injury or other medical conditions (If "yes", provide details in Section IV.)	☐	☐
164. Have you ever been denied life insurance? (If "yes", provide reason(s) in Section IV.)	☐	☐

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*	DoD ID NUMBER *(If applicable)*

SECTION IV - APPLICANT COMMENTS. Explain all "Yes" answers to questions 1 - 164 above.
Begin with the Item Number. Describe answer(s) fully: provide date(s) of problem(s)/condition(s); provide names of Health Care Providers (HCPs), Clinic(s) and/or Hospital(s) along with the City and State; explain what was done (e.g., evaluation and/or treatment); and describe your current medical status. Attach additional sheet(s) if necessary and sign and date each additional page. Obtain and attach copies of applicable medical evaluation and treatment records.

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LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*	DoD ID NUMBER *(If applicable)*

SECTION V - HEALTH CARE PROVIDER/INSURANCE CARRIER CONTACT INFORMATION:

Current Primary Care Physician(s)/Practitioner(s) and/or Clinic(s) where care is received and Current/Previous Insurance Carrier(s) information. Attach additional sheets if necessary.

1. CURRENT PRIMARY CARE PHYSICIAN(S)/PRACTITIONER(S) AND/OR CLINIC(S)

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

2. PREVIOUS PRIMARY CARE PHYSICIAN(S)/PRACTITIONER(S) AND/OR CLINIC(S)

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

3. CURRENT INSURANCE AND/OR PHARMACY BENEFIT MANAGER(S)

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

4. PREVIOUS INSURANCE AND/OR PHARMACY BENEFIT MANAGER(S)

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

5. ADDITIONAL ISSURANCE AND/OR PHARMACY BENIFIT MANAGER(S)

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

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*	DoD ID NUMBER *(If applicable)*

SECTION VI - MEDICAL RECORDS RELEASE

Applicant (Patient) Name:	Social Security Number:

Date of Birth (*MM/DD/YYYY)*	Phone:	Address:

1. I authorize the release of the following information by *ALL* holders of my medical records/information (check all applicable) Choosing not to release all records will delay medical qualification determination.

☐ All records	☐ Abstract	☐ Inpatient medical records
☐ Outpatient medical records	☐ Laboratory/pathology records	☐ X-ray films/radiology records
☐ Billing records	☐ Pharmacy/prescription records	☐ Psychotherapy/psychiatic care records
☐ HIV, drug, and/or alcohol use records	☐ Other	

Describe specifically:

2. Please send my records listed above to:

Name:	Address:

Phone:	Fax:

3. I authorize the release of the medical records that I marked above through an electronic health exchange if available.

4. I understand that if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

5. This authorization for medical records release will expire no later than 2 years from the date of signature or as directed by local laws. I understand written notification is necessary to cancel this authorization before such date and can be addressed to the department listed at item 2 of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

6. I understand that this disclosure may include information regarding drug abuse, alcoholism, or alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV regulated by Federal Statute (42 CFR Part 2).

7. Applicant

a. Signature	b. Date Signed *(YYYYMMDD)*

8. Parent or Guardian Signature is mandatory for minor applicant, signature is optional if applicant is of age

a. NAME *(Last, First, Middle Initial)*	b. Signature	c. Date Signed *(YYYYMMDD)*

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*	DoD ID NUMBER *(If applicable)*

SECTION VII - MEDICAL PROVIDER'S SUMMARY AND DESCRIPTION OF PERTINENT INFORMATION:
Review and comment on all medical records, electronically provided medical history information, and other electronic data available in the Department of Defense Accessions Processing System. Medical providers may also develop any additional medical history deemed important and record significant findings here or by interview and document them on DD Form 2808, "Report of Medical Examination". Attach additional sheet(s) if necessary.

COMMENTS:

NEED DD 67

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*	DoD ID NUMBER *(If applicable)*

SECTION VIII - MEDICAL PROVIDER'S PRESCREEN DETERMINATION BASED ON AVAILABLE INFORMATION:

1.a. DATE *(YYYYMMDD)*	b. MEDICAL PROCESSING STATUS						c. IF NOT WITHIN STANDARDS:				d. PROVIDER INITIALS
	PA	PRW	PH	RJ	METR	PNJ	ICD	CONDITION	PULHES	SMWRA INPUT	

KEY: PA = Processing Authorized; PRW = Processing Requested by SMWRA; PH = Processing Hold; RJ = Return Justified; METR = Medical Evaluation and/or Treatment Records; PNJ = Processing Not Justified; ICD = International Classification of Disease Code; PULHES = P (Physical Capacity), U (Upper Extremities), L (Lower Extremities), H (Hearing), E (Eyes), S (Psychiatric); SMWRA = Service Medical Waiver Review Authority.

2. *FOR MEPS USE ONLY:

ON EXAM:	a. PSN COMP	b. PSN INCOM	c. NPS	d. *AE	e. *RE	f. *ME	g. *OE	h. DATE *(YYYYMMDD)*	i. PROVIDER INITIALS

3. AUTHORIZING MEDICAL PROVIDER

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

4. EXAMINING PROVIDER

a. NAME *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*	5. NUMBER OF ADDITIONAL SHEETS SUBMITTED