

**ACCESSIONS MEDICAL HISTORY REPORT**

OMB No. 0704-0413  
OMB Approval Expires:  
20241031

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, at [whs.mc-alex.esd.mbx.dd-dodinformationcollections@mail.mil](mailto:whs.mc-alex.esd.mbx.dd-dodinformationcollections@mail.mil). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. **PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.**

**PRIVACY ACT STATEMENT**

**AUTHORITY:** 10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. Subtitle A, General Military Law, Part II, Personnel (Chapter 31, Enlistments and Chapter 33, Original Appointments of Regular Officers in Grades Above Warrant Officer Grades); 10 U.S.C. 3013, Secretary of the Army; 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 8013, Secretary of the Air Force; DoD Directive (DoDD) 1145.02E, United States Military Entrance Processing Command (USMEPCOM); DoD Instruction (DoDI) 1304.02, Accession Processing Data Collection Forms; DoDI 1304.12E, DoD Military Personnel Accession Testing Programs; DoDI 1304.26, Qualification Standards for Enlistment, Appointment and Induction; DoDI 1332.18, Disability Evaluation System; DoDI 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services; DoD Manual 1145.02, Military Entrance Processing Station (MEPS); USMEPCOM Regulation 680-3, Entrance Processing and Reporting System Management; and E.O. 9397 (SSN), as amended.

**PURPOSE:** To obtain medical data for determination of medical fitness for enlistment, induction, appointment, and retention for applicants and members of the Armed Forces. This form may also be used by Medical Evaluation Boards to determine the medical fitness of a current member and if separation is warranted.

**ROUTINE USE(S):** Disclosure of records are generally permitted under 5 U.S.C. 522a(b) of the Privacy Act of 1974, as amended. Pursuant to 5 U.S.C. 522a(b)(3), records may be disclosed as a routine use to Federal, State and local health departments for compliance with public health communicable disease reporting laws in accordance with 42 U.S.C. 264. A complete list of routine uses may be found in the applicable System of Records Notice, United States Military Entrance Processing Command (USMEPCOM) Integrated Resource System (USMIRS), A0601-270 at: <https://www.federalregister.gov/documents/2021/04/21/2021-08286/privacy-act-of-1974-system-of-records>.

**DISCLOSURE:** Voluntary; however, failure to provide the requested information may result in an inability to process your application for enlistment or appointment in the Armed Forces. For current Armed Forces members, failure to provide the requested information may result in being placed in non-deployable status.

**Additional system of records notices:**

Physical/Medical Evaluation Records

Army: <https://dpclid.defense.gov/Privacy/SORNSIndex/DOD-wide-SORN-Article-View/Article/569965/a0040-3b-dasg/>

Navy: <https://dpclid.defense.gov/Privacy/SORNSIndex/DOD-wide-SORN-Article-View/Article/570339/nm01850-2/>

Air Force: <https://dpclid.defense.gov/Privacy/SORNSIndex/DOD-wide-SORN-Article-View/Article/569861/>

**SECTION I – APPLICANT INFORMATION**

1. LAST NAME – FIRST NAME – MIDDLE INITIAL ( <i>Suffix</i> )	2. AGE	3. DATE OF BIRTH (YYYYMMDD)	4.a. SOCIAL SECURITY NUMBER	4.b. DoD ID NUMBER ( <i>If applicable</i> )
5. ( <i>X each item</i> ) a. SEX ( <i>at birth</i> ) <input type="checkbox"/> Male <input type="checkbox"/> Female	b. GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	6.a. SERVICE PROCESSING FOR ( <i>X as applicable</i> ) <input type="checkbox"/> Army <input type="checkbox"/> Space Force <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard <input type="checkbox"/> USPHS <input type="checkbox"/> Space Force <input type="checkbox"/> NOAA <input type="checkbox"/> Other: _____		6.b. COMPONENT ( <i>X as applicable</i> ) <input type="checkbox"/> Regular <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard
7. PURPOSE OF EXAMINATION ( <i>X as applicable</i> ) <input type="checkbox"/> Enlistment <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Commission <input type="checkbox"/> ROTC Scholarship <input type="checkbox"/> Other: _____		8. POSITION ( <i>If current Federal Employee</i> ) ( <i>Job Title, Grade, Component</i> )		

**SECTION II - APPLICANT (OR PARENT/GUARDIAN) AUTHORIZATION STATEMENT**

- I Have read and understand the warning and penalties that are associated with providing a false statement.
- I Agree that all protected health information and personally identifiable information (PHI/PII) or data disclosed by myself or others on my behalf with my consent during the accession process is no longer protected by federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules and may be further disseminated as needed.
- I Authorize release of medical records and information relating to grades, performance, individual education plans, and disciplinary proceedings. Under the Family Educational Rights and Privacy Act (FERPA), United States Military Entrance Processing Command (USMEPCOM)/Department of Defense Medical Examination Review Board (DoDMERB) is authorized to receive all of my education/disciplinary records for evaluation of my suitability for Military Service.
- I Understand that a medical examination is part of the accession evaluation, may require several visits to the Military Entrance Processing Station (MEPS), or DoDMERB contracted medical center. I may have blood work and/or other medical tests, procedures such as cerumen removal, and/or specialty consultations performed as part of my processing.
- I Understand that the results of the examination, tests, and consults are not performed as part of an individual healthcare treatment plan, but will be reviewed and considered as part of my accession application file.
- I Understand that the MEPS/DoDMERB medical staff are not my healthcare providers. If I do not receive notice of an abnormal result of a test or a consultation, I am not to assume that the result is normal. Furthermore, if any test or consultation results are abnormal, then I am responsible for obtaining those results from the MEPS/DoDMERB contracted medical center. I am also responsible for any necessary follow-up evaluations and/or treatment. If I am notified to return to the MEPS/DoDMERB contracted medical center to discuss medical results, it is my responsibility to take quick action to return to the MEPS/DoDMERB contracted medical center.
- I Understand that neither USMEPCOM nor DoDMERB are financially responsible for costs associated with any necessary follow-up evaluations and/or treatment based on my screening evaluation.
- I Understand that 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 Authorize a MEPS/DoDMERB contracted medical center to perform my accession medical evaluation.
- I Understand that I have the right to refuse to sign this authorization, however I also understand that failure to do so will prevent my further processing.
- I Understand that this authorization will expire four years from the date of the signature below, or sooner if written request is received by the USMEPCOM/DoDMERB Privacy 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 AUTHORIZATION AND CERTIFICATION**

I Certify that 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 medical and mental/behavioral health history.

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

**2. PARENT OR GUARDIAN AUTHORIZATION (*Signature is mandatory if applicant is a minor*)**

a. NAME ( <i>Last, First, Middle Initial</i> )	b. SIGNATURE	c. DATE SIGNED (YYYYMMDD)
--	--------------	------------------------------

**3. RECRUITING REPRESENTATIVE CERTIFICATION: (*If applicable*) I certify that all applicant information above is complete and true to the best of my knowledge.**

a. NAME ( <i>Last, First, Middle Initial</i> )	b. RECRUITER IDENTIFICATION NUMBER	c. SIGNATURE	d. DATE SIGNED (YYYYMMDD)
--	------------------------------------	--------------	------------------------------

**CUI (when filled in)**

LAST NAME – FIRST NAME – MIDDLE INITIAL ( <i>Suffix</i> )		SOCIAL SECURITY NUMBER		DoD ID NUMBER ( <i>If applicable</i> )			
<b>SECTION III - MEDICAL HISTORY</b>							
1. Medications: any prescription or over the counter medication(s) taken regularly or as needed ( <i>list each and explain in SECTION IV</i> )			2. Allergies: reaction to food(s), insect bites/stings, medication(s) or other substances ( <i>list each and explain in SECTION IV</i> )				
Read each of the following questions and answer by checking "YES" or "NO". Every question must be answered. Every "YES" answer must be explained in SECTION IV. Explain each item to the best of your ability. Your medical records may be requested to clarify your medical history.							
HAVE YOU EVER HAD OR DO YOU NOW HAVE:		YES	NO	HAVE YOU EVER HAD OR DO YOU NOW HAVE:		YES	NO
<b>EYES/VISION:</b>				<b>UPPER EXTREMITIES: (Continued)</b>			
3. Double vision				60. Dislocated shoulder, elbow, or wrist			
4. Detached retina or surgery to repair a detached retina				<b>LOWER EXTREMITIES:</b>			
5. Keratoconus, glaucoma, cataracts or surgery for cataracts				61. Foot conditions such as plantar fasciitis, heel spur, or painful bunions			
6. Vision correction procedure such as Lasik, PRK, or lens implant				62. Knee injury resulting in ligament/cartilage tear, instability, or locking			
7. Night blindness				63. Any pain, swelling, weakness, numbness, or stiffness of the hip, knee, ankle, foot, or toes			
8. Any other eye condition, injury, or surgery/procedure				64. Dislocated hip, knee, ankle, or foot			
<b>EARS/HEARING:</b>				<b>MISCELLANEOUS CONDITIONS OF THE EXTREMITIES:</b>			
9. Cholesteatoma				65. Bone, muscle, or joint deformity, injury, or persistent pain/swelling			
10. Ear drum perforation or tubes inserted into the ear drum(s) in the past 12 months				66. Impaired use of arms, hands, fingers, legs, feet, or toes ( <i>any reason</i> )			
11. Any other ear surgery or procedure including mastoidectomy				67. Joint swelling/inflammation such as arthritis, gout, or bursitis			
12. Loss of balance or vertigo				68. Compartment syndrome, shin splints, or stress reaction/fracture			
13. Hearing loss or use of hearing aid(s)				69. Any surgery of the bone or joint such as placing a screw, plate, rod, pin, prosthetic/graft or arthroscopy			
<b>NOSE, SINUSES, MOUTH, AND LARYNX:</b>				70. Any use of prescribed corrective/prosthetic devices such as a brace, back support, heel lift, or orthotic inserts			
14. Ear, nose, or throat conditions such as vocal cord dysfunction				<b>VASCULAR:</b>			
15. Recurrent nose bleeds, chronic sinus infections, or sinus surgery				71. Abnormal ( <i>high or low</i> ) blood pressure			
16. Absence of, or disturbance of sense of smell				72. Pale, blue, or numb fingers or toes with exposure to cold such as Raynaud's phenomenon/disease			
17. Any surgery of the face, throat, or jaw				73. Kawasaki disease			
<b>DENTAL: (If you wear braces/aligners, then you must submit a letter from your orthodontist stating that active orthodontic treatment will be completed before beginning active duty)</b>				<b>SKIN:</b>			
18. Braces or aligners				74. Acne that required prescription medication(s)			
19. Any tooth or gum problems				75. Skin rash such as atopic dermatitis, eczema, or psoriasis			
<b>LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM:</b>				76. Any other skin condition such as recurrent hives, abscesses ( <i>hidradenitis</i> ), pilonidal cyst, or cancer ( <i>melanoma</i> )			
20. Asthma, asthmatic bronchitis, wheezing, shortness of breath, or other breathing problems worsened by exercise, weather, pollens, etc.				<b>BLOOD AND BLOOD FORMING SYSTEM:</b>			
21. Prescription for an inhaler, steroids, or any other medication for breathing problem				77. Anemia such as iron deficiency, sickle cell, or thalassemia			
22. Pneumonia				78. Blood clot(s), a clotting disorder, or history of taking a blood thinner			
23. Chronic cough or frequent coughing at night				79. Absence or removal of the spleen			
24. Collapsed lung or other lung condition(s)				80. Prolonged bleeding such as after an injury or dental procedure			
25. History of chest, chest wall, or breast surgery				81. Any other blood or circulation condition			
<b>HEART:</b>				<b>SYSTEMIC:</b>			
26. Heart murmur or valve problem(s)				82. Severe allergic reaction to any substance requiring emergency care			
27. Palpitations, skipped/abnormal heartbeats, or pounding heart				83. Tested positive for tuberculosis ( <i>skin or blood test</i> ), or lived with someone who had it			
28. Chest pain/pressure or an abnormal electrocardiogram (EKG)				84. Immune system condition such as rheumatoid arthritis, lupus, multiple sclerosis, or AIDS			
29. Heart surgery				85. Sexually transmitted disease such as herpes, syphilis, gonorrhea, chlamydia, or HIV			
30. Any other heart condition				86. Rhabdomyolysis			
<b>ABDOMEN AND GASTROINTESTINAL SYSTEM:</b>				<b>ENDOCRINE AND METABOLIC:</b>			
31. Problems of the stomach, esophagus, or intestine such as ulcer(s)				87. Thyroid conditions such as goiter or hypo/hyperthyroidism			
32. Frequent indigestion/heartburn, difficulty swallowing, or eosinophilic esophagitis				88. Diabetes or hypoglycemia ( <i>low blood sugar</i> )			
33. Gallbladder disease or gallstones				89. Any other endocrine ( <i>hormone</i> ) condition such as growth hormone deficiency, adrenal insufficiency, or hypo/hyperparathyroidism			
34. Hepatitis or jaundice ( <i>except neonatal jaundice</i> )				<b>NEUROLOGIC:</b>			
35. Hernia				90. Stroke, aneurysm, or bleeding in or around the brain			
36. Any abdominal surgery/endoscopy such as appendectomy, bowel resection, hernia repair, or colonoscopy				91. Frequent or severe headaches such as migraines, cluster, or tension			
37. Weight loss surgery such as gastric bypass or lap banding				92. A head injury, concussion, or skull fracture			
38. Chronic or recurrent intestinal disease such as irritable bowel syndrome, inflammatory bowel disease, or celiac disease				93. Infection of the brain or spinal cord such as abscess, meningitis, or encephalitis			
39. Anorectal disease, blood from the rectum, or hemorrhoids				94. Seizures, epilepsy, or convulsions			
<b>FEMALES ONLY:</b>				95. Syncope or fainting spells			
40. First day of the last menstrual period (YYYYMMDD)				96. Any other neurologic condition such as paralysis, myasthenia gravis, Tourette's, or memory loss			
41. A change in menstrual pattern ( <i>other than pregnancy</i> )				<b>SLEEP:</b>			
42. Pregnancy				97. Sleep apnea			
43. Any abnormal PAP test				98. Sleepwalking, narcolepsy, or difficulty with sleep such as falling/staying asleep			
44. Endometriosis, uterine fibroid, or ovarian cyst				<b>LEARNING, PSYCHIATRIC, AND BEHAVIORAL:</b>			
45. Any other gynecological disorder that required evaluation, treatment, or surgery				99. Attention Deficit or Hyperactivity disorder ( <i>ADD/ADHD</i> ), dyslexia, autism spectrum, or other learning disorder			
<b>MALES ONLY:</b>				100. A behavioral/mental health condition such as anxiety/panic attacks, depression, adjustment disorder, PTSD, personality disorder, addiction, or drug/substance abuse including alcohol			
46. Undescended/absent testicle(s), or testicular implant				101. Evaluation or treatment either with medication or counseling for any behavioral/mental health condition			
47. Any scrotal mass, swelling, or pain				102. Eating disorder such as anorexia or bulimia			
48. Prostate problems				103. Self-inflicted injury such as cutting or burning			
<b>URINARY SYSTEM:</b>				104. Suicidal thoughts, gesture, or attempt			
49. Absence of, or a congenital abnormality of a kidney such as horseshoe kidney				105. Admission to a hospital for any behavioral/mental health condition			
50. Blood or protein in urine				<b>TUMORS AND MALIGNANCIES:</b>			
51. Painful or difficult urination				106. Any cancer, malignancy, tumor, or cyst			
52. Kidney stone				<b>MISCELLANEOUS:</b>			
53. Kidney or urinary tract disease, surgery, or infection				107. Cold/heat intolerance or injury such as frostbite or heatstroke			
54. Bedwetting or treatment for bedwetting in the past 12 months				<b>SUPPLEMENTAL QUESTIONS:</b>			
<b>SPINE AND SACROILIAC JOINTS:</b>				108. Prosthetic body part or joint			
55. Back or neck pain, or herniated disc				109. Any medical treatment/surgery from a Hospital, Emergency Room, Surgical Center or Urgent Care			
56. Abnormal curvature of any part of the spine				110. Previous medical disqualification for Military Service			
57. Vertebral fracture or stress injury of the spine such as spondylolysis				111. Discharge from Military Service for any reason ( <i>provide reason, date, and type of discharge</i> )			
58. Back or neck surgery				112. Disability award or compensation for an injury or other medical condition			
<b>UPPER EXTREMITIES:</b>							
59. Any pain, swelling, weakness, numbness, or stiffness of the shoulder, elbow, wrist, hand, or fingers							

LAST NAME – FIRST NAME – MIDDLE INITIAL <i>(Suffix)</i>	SOCIAL SECURITY NUMBER	DoD ID NUMBER <i>(If applicable)</i>
---	------------------------	--------------------------------------

**SECTION IV – APPLICANT COMMENTS**

Explain all "YES" answers to questions above. Write the item number and provide details to include the following: description of the problem/condition, date of onset of the problem/condition, date of treatment, name of health care provider, clinic, center, hospital along with City and State. Comment on the current status of the problem/condition. Attach additional sheet(s) if necessary, and sign and date each additional sheet. Attach copies of all applicable medical records.

DRAFT

LAST NAME – FIRST NAME – MIDDLE INITIAL <i>(Suffix)</i>	SOCIAL SECURITY NUMBER	DoD ID NUMBER <i>(If applicable)</i>
---	------------------------	--------------------------------------

**SECTION V – MEDICAL PROVIDER SUMMARY**  
The medical provider will review all applicant comments on "YES" answers, and all submitted supporting medical documentation. The provider will comment below on each "YES" answer. Attach additional sheets if necessary.

DRAFT

**CUI (when filled in)**

LAST NAME – FIRST NAME – MIDDLE INITIAL <i>(Suffix)</i>	SOCIAL SECURITY NUMBER	DoD ID NUMBER <i>(If applicable)</i>
---	------------------------	--------------------------------------

**SECTION VI - PRESCREEN PROCESSING DETERMINATION**

1.a. MEDICAL PROCESSING STATUS				1.b. REVIEWER INITIALS	1.c. DATE (YYYYMMDD)
PA	PH	RJ	METR		

**KEY:** PA = Processing Authorized; PH = Processing Hold; RJ = Return Justified; METR = Medical Evaluation and/or Treatment Records

**2. AUTHORIZING MEDICAL PROVIDER**

a. NAME <i>(Last, First, Middle Initial)</i>	b. SIGNATURE	c. DATE SIGNED (YYYYMMDD)	d. NUMBER OF ADDITIONAL SHEETS ATTACHED

**SECTION VII – INTERVIEWING MEDICAL PROVIDER COMMENTS**

DRAFT

**3. INTERVIEWING MEDICAL PROVIDER**

a. NAME <i>(Last, First, Middle Initial)</i>	b. SIGNATURE	c. DATE SIGNED (YYYYMMDD)