ACCESSIONS MEDICAL HISTORY REPORT

OMB No. 0704-0413
OMB Approval Expires: 20241031

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 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. 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 system of records notice found at: **https://www.federalregister.gov/documents/2021/04/21/2021-08286/privacy-act-of-1974-system-of-records**

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 INFORMATION

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

5. *(X each item)*	6.a. SERVICE PROCESSING FOR *(X as applicable)*	6.b. COMPONENT *(X as applicable)*
a. SEX *(at birth)* ☐ Male ☐ Female b. GENDER ☐ Male ☐ Female	☐ Army ☐ Space Force ☐ Navy ☐ Marine Corps ☐ Air Force ☐ Coast Guard ☐ Other: _____	☐ Regular ☐ Reserve ☐ National Guard

7. PURPOSE OF EXAMINATION *(X as applicable)*	8. POSITION *(If current Federal Employee) (Job Title, Grade, Component)*
☐ Enlistment ☐ U.S. Service Academy ☐ Commission ☐ ROTC Scholarship ☐ Other: _____	

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 *(Last, First, Middle Initial)*	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 *(Last, First, Middle Initial)*	b. RECRUITER IDENTIFICATION NUMBER	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*

LAST NAME – FIRST NAME – MIDDLE INITIAL *(Suffix)*	SOCIAL SECURITY NUMBER	DoD ID NUMBER *(If applicable)*

SECTION III - MEDICAL HISTORY

1. Medications: any prescription or over the counter medication(s) taken regularly or as needed *(list each and explain in SECTION IV)*	2. Allergies: reaction to food(s), insect bites/stings, medication(s) or other substances *(list each and explain in SECTION IV)*

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
EYES/VISION:		
3. Double vision	☐	☐
4. Detached retina or surgery to repair a detached retina	☐	☐
5. Keratoconus, glaucoma, cataracts or surgery for cataracts	☐	☐
6. Vision correction procedure such as Lasik, PRK, or lens implant	☐	☐
7. Night blindness	☐	☐
8. Any other eye condition, injury, or surgery/procedure	☐	☐
EARS/HEARING:		
9. Cholesteatoma	☐	☐
10. Ear drum perforation or tubes inserted into the ear drum(s) in the past 12 months	☐	☐
11. Any other ear surgery or procedure including mastoidectomy	☐	☐
12. Loss of balance or vertigo	☐	☐
13. Hearing loss or use of hearing aid(s)	☐	☐
NOSE, SINUSES, MOUTH, AND LARYNX:		
14. Ear, nose, or throat conditions such as vocal cord dysfunction	☐	☐
15. Recurrent nose bleeds, chronic sinus infections, or sinus surgery	☐	☐
16. Absence of, or disturbance of sense of smell	☐	☐
17. Any surgery of the face, throat, or jaw	☐	☐
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)*		
18. Braces or aligners	☐	☐
19. Any tooth or gum problems	☐	☐
LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM:		
20. Asthma, asthmatic bronchitis, wheezing, shortness of breath, or other breathing problems worsened by exercise, weather, pollens, etc.	☐	☐
21. Prescription for an inhaler, steroids, or any other medication for breathing problem	☐	☐
22. Pneumonia	☐	☐
23. Chronic cough or frequent coughing at night	☐	☐
24. Collapsed lung or other lung condition(s)	☐	☐
25. History of chest, chest wall, or breast surgery	☐	☐
HEART:		
26. Heart murmur or valve problem(s)	☐	☐
27. Palpitations, skipped/abnormal heartbeats, or pounding heart	☐	☐
28. Chest pain/pressure or an abnormal electrocardiogram (EKG)	☐	☐
29. Heart surgery	☐	☐
30. Any other heart condition	☐	☐
ABDOMEN AND GASTROINTESTINAL SYSTEM:		
31. Problems of the stomach, esophagus, or intestine such as ulcer(s)	☐	☐
32. Frequent indigestion/heartburn, difficulty swallowing, or eosinophilic esophagitis	☐	☐
33. Gallbladder disease or gallstones	☐	☐
34. Hepatitis or jaundice *(except neonatal jaundice)*	☐	☐
35. Hernia	☐	☐
36. Any abdominal surgery/endoscopy such as appendectomy, bowel resection, hernia repair, or colonoscopy	☐	☐
37. Weight loss surgery such as gastric bypass or lap banding	☐	☐
38. Chronic or recurrent intestinal disease such as irritable bowel syndrome, inflammatory bowel disease, or celiac disease	☐	☐
39. Anorectal disease, blood from the rectum, or hemorrhoids	☐	☐
FEMALES ONLY:		
40. First day of the last menstrual period *(YYYYMMDD)*		
41. A change in menstrual pattern *(other than pregnancy)*	☐	☐
42. Pregnancy	☐	☐
43. Any abnormal PAP test	☐	☐
44. Endometriosis, uterine fibroid, or ovarian cyst	☐	☐
45. Any other gynecological disorder that required evaluation, treatment, or surgery	☐	☐
MALES ONLY:		
46. Undescended/absent testicle(s), or testicular implant	☐	☐
47. Any scrotal mass, swelling, or pain	☐	☐
48. Prostate problems	☐	☐
URINARY SYSTEM:		
49. Absence of, or a congenital abnormality of a kidney such as horseshoe kidney	☐	☐
50. Blood or protein in urine	☐	☐
51. Painful or difficult urination	☐	☐
52. Kidney stone	☐	☐
53. Kidney or urinary tract disease, surgery, or infection	☐	☐
54. Bedwetting or treatment for bedwetting in the past 12 months	☐	☐
SPINE AND SACROILIAC JOINTS:		
55. Back or neck pain, or herniated disc	☐	☐
56. Abnormal curvature of any part of the spine	☐	☐
57. Vertebral fracture or stress injury of the spine such as spondylolysis	☐	☐
58. Back or neck surgery	☐	☐
UPPER EXTREMITIES:		
59. Any pain, swelling, weakness, numbness, or stiffness of the shoulder, elbow, wrist, hand, or fingers	☐	☐

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
UPPER EXTREMITIES: *(Continued)*		
60. Dislocated shoulder, elbow, or wrist	☐	☐
LOWER EXTREMITIES:		
61. Foot conditions such as plantar fasciitis, heel spur, or painful bunions	☐	☐
62. Knee injury resulting in ligament/cartilage tear, instability, or locking	☐	☐
63. Any pain, swelling, weakness, numbness, or stiffness of the hip, knee, ankle, foot, or toes	☐	☐
64. Dislocated hip, knee, ankle, or foot	☐	☐
MISCELLANEOUS CONDITIONS OF THE EXTREMITIES:		
65. Bone, muscle, or joint deformity, injury, or persistent pain/swelling	☐	☐
66. Impaired use of arms, hands, fingers, legs, feet, or toes *(any reason)*	☐	☐
67. Joint swelling/inflammation such as arthritis, gout, or bursitis	☐	☐
68. Compartment syndrome, shin splints, or stress reaction/fracture	☐	☐
69. Any surgery of the bone or joint such as placing a screw, plate, rod, pin, prosthetic/graft or arthroscopy	☐	☐
70. Any use of prescribed corrective/prosthetic devices such as a brace, back support, heel lift, or orthotic inserts	☐	☐
VASCULAR:		
71. Abnormal *(high or low)* blood pressure	☐	☐
72. Pale, blue, or numb fingers or toes with exposure to cold such as Raynaud's phenomenon/ disease	☐	☐
73. Kawasaki disease	☐	☐
SKIN:		
74. Acne that required prescription medication(s)	☐	☐
75. Skin rash such as atopic dermatitis, eczema, or psoriasis	☐	☐
76. Any other skin condition such as recurrent hives, abscesses *(hidradenitis)*, pilonidal cyst, or cancer *(melanoma)*	☐	☐
BLOOD AND BLOOD FORMING SYSTEM:		
77. Anemia such as iron deficiency, sickle cell, or thalassemia	☐	☐
78. Blood clot(s), a clotting disorder, or history of taking a blood thinner	☐	☐
79. Absence or removal of the spleen	☐	☐
80. Prolonged bleeding such as after an injury or dental procedure	☐	☐
81. Any other blood or circulation condition	☐	☐
SYSTEMIC:		
82. Severe allergic reaction to any substance requiring emergency care	☐	☐
83. Tested positive for tuberculosis *(skin or blood test)*, or lived with someone who had it	☐	☐
84. Immune system condition such as rheumatoid arthritis, lupus, multiple sclerosis, or AIDS	☐	☐
85. Sexually transmitted disease such as herpes, syphilis, gonorrhea, chlamydia, or HIV	☐	☐
86. Rhabdomyolysis	☐	☐
ENDOCRINE AND METABOLIC:		
87. Thyroid conditions such as goiter or hypo/hyperthyroidism	☐	☐
88. Diabetes or hypoglycemia *(low blood sugar)*	☐	☐
89. Any other endocrine *(hormone)* condition such as growth hormone deficiency, adrenal insufficiency, or hypo/hyperparathyroidism	☐	☐
NEUROLOGIC:		
90. Stroke, aneurysm, or bleeding in or around the brain	☐	☐
91. Frequent or severe headaches such as migraines, cluster, or tension	☐	☐
92. A head injury, concussion, or skull fracture	☐	☐
93. Infection of the brain or spinal cord such as abscess, meningitis, or encephalitis	☐	☐
94. Seizures, epilepsy, or convulsions	☐	☐
95. Syncope or fainting spells	☐	☐
96. Any other neurologic condition such as paralysis, myasthenia gravis, Tourette's, or memory loss	☐	☐
SLEEP:		
97. Sleep apnea	☐	☐
98. Sleepwalking, narcolepsy, or difficulty with sleep such as falling/staying asleep	☐	☐
LEARNING, PSYCHIATRIC, AND BEHAVIORAL:		
99. Attention Deficit or Hyperactivity disorder *(ADD/ADHD)*, dyslexia, autism spectrum, or other learning disorder	☐	☐
100. A behavioral/mental health condition such as anxiety/panic attacks, depression, adjustment disorder, PTSD, personality disorder, addiction, or drug/substance abuse including alcohol	☐	☐
101. Evaluation or treatment either with medication or counseling for any behavioral/mental health condition	☐	☐
102. Eating disorder such as anorexia or bulimia	☐	☐
103. Self-inflicted injury such as cutting or burning	☐	☐
104. Suicidal thoughts, gesture, or attempt	☐	☐
105. Admission to a hospital for any behavioral/mental health condition	☐	☐
TUMORS AND MALIGNANCIES:		
106. Any cancer, malignancy, tumor, or cyst	☐	☐
MISCELLANEOUS:		
107. Cold/heat intolerance or injury such as frostbite or heatstroke	☐	☐
SUPPLEMENTAL QUESTIONS:		
108. Prosthetic body part or joint	☐	☐
109. Any medical treatment/surgery from a Hospital, Emergency Room, Surgical Center or Urgent Care	☐	☐
110. Previous medical disqualification for Military Service	☐	☐
111. Discharge from Military Service for any reason *(provide reason, date, and type of discharge)*	☐	☐
112. Disability award or compensation for an injury or other medical condition	☐	☐

LAST NAME – FIRST NAME – MIDDLE INITIAL *(Suffix)*	SOCIAL SECURITY NUMBER	DoD ID NUMBER *(If applicable)*

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.

LAST NAME – FIRST NAME – MIDDLE INITIAL *(Suffix)*	SOCIAL SECURITY NUMBER	DoD ID NUMBER *(If applicable)*

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.

LAST NAME – FIRST NAME – MIDDLE INITIAL *(Suffix)*	SOCIAL SECURITY NUMBER	DoD ID NUMBER *(If applicable)*

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 *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE SIGNED *(YYYYMMDD)*	d. NUMBER OF ADDITIONAL SHEETS ATTACHED

SECTION VII – INTERVIEWING MEDICAL PROVIDER COMMENTS

3. INTERVIEWING MEDICAL PROVIDER

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