

## ACCESSIONS MEDICAL HISTORY REPORT

OMB No. 0704-0413  
OMB Approval Expires:  
20241031

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### 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 ( <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"/> 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)
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#### 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)
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#### 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)
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**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				YES	
NO				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					

**CUI (when filled in)**

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

*(This area is intentionally left blank for the applicant to provide comments.)*

**CUI (when filled in)**

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

*(This area is intentionally left blank for the medical provider to provide a summary of comments on "YES" answers and supporting medical documentation.)*

**CUI (when filled in)**

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

**3. INTERVIEWING MEDICAL PROVIDER**

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