

Physical Examination Packet 1

1. This packet has been prepared to assist you in completing your physical examination for a: Periodic, Diving, Over 40, Appointment/Commission, Military School, Special Forces, Ranger School, MEB, FYGME, Fitness for Duty, NOAA, ROTC and USPHS physical.

2. This packet includes a clinic checklist and forms that you must complete prior to your Part II visit. You can fill out the forms online and print them out and bring them with you; or you can print out the packet and complete the information by hand. Please use black ink, when completing the forms by hand.

- Clinic Checklist.
- DD Form 2807-1, Report of Medical History, with instructions on how to complete the form.
- DD Form 2808, Report of Medical Examination, with instructions on how to complete the form.
- Consent for HIV (AIDS VIRUS) Testing, with Patient Instructions for HIV (AIDS VIRUS) Testing.

This packet was last updated on Thursday, January 24, 2008.

Last Name / Last 4 _____

This checklist has been prepared to assist you in completing your physical examination. Please finish all clinic visits checked below prior to your Part II so that the physician can review all of the test results with you. NOTE: Fill in all forms as per instructions. If you have any problems or questions call 433-3345 for assistance.

___ **LABORATORY** (blood and urine tests) Wing G, 4th Floor. Phone: 433-6664. Twelve (12) hour fasting required. You may have water only during this time.

___ **AUDIOLOGY CLINIC** (hearing test) Wing C, 3rd Floor. APPOINTMENT at: _____ (BY APPOINTMENT ONLY). Active Duty personnel must have their medical records.

___ **OPTOMETRY CLINIC** (vision screening) Wing H, 4th Floor. Times: Wed and Fri 0800-1100. PLEASE BRING YOUR GLASSES IF YOU WEAR CORRECTIVE LENSES. Phone: 433-3211

___ **CARDIOLOGY CLINIC** (EKG) Wing A, 4th Floor. Phone: 433-6390. CLOSED THURSDAY AND FRIDAY AFTER 1300

___ **RADIOLOGY** (X-ray) Wing G, 3rd Floor. Phone: 433-6669

___ **GYN CLINIC** (GYN exam) Wing H, 4th Floor. BY APPOINTMENT ONLY. Phone: 433-2778 for a "Well Woman Exam" appointment.

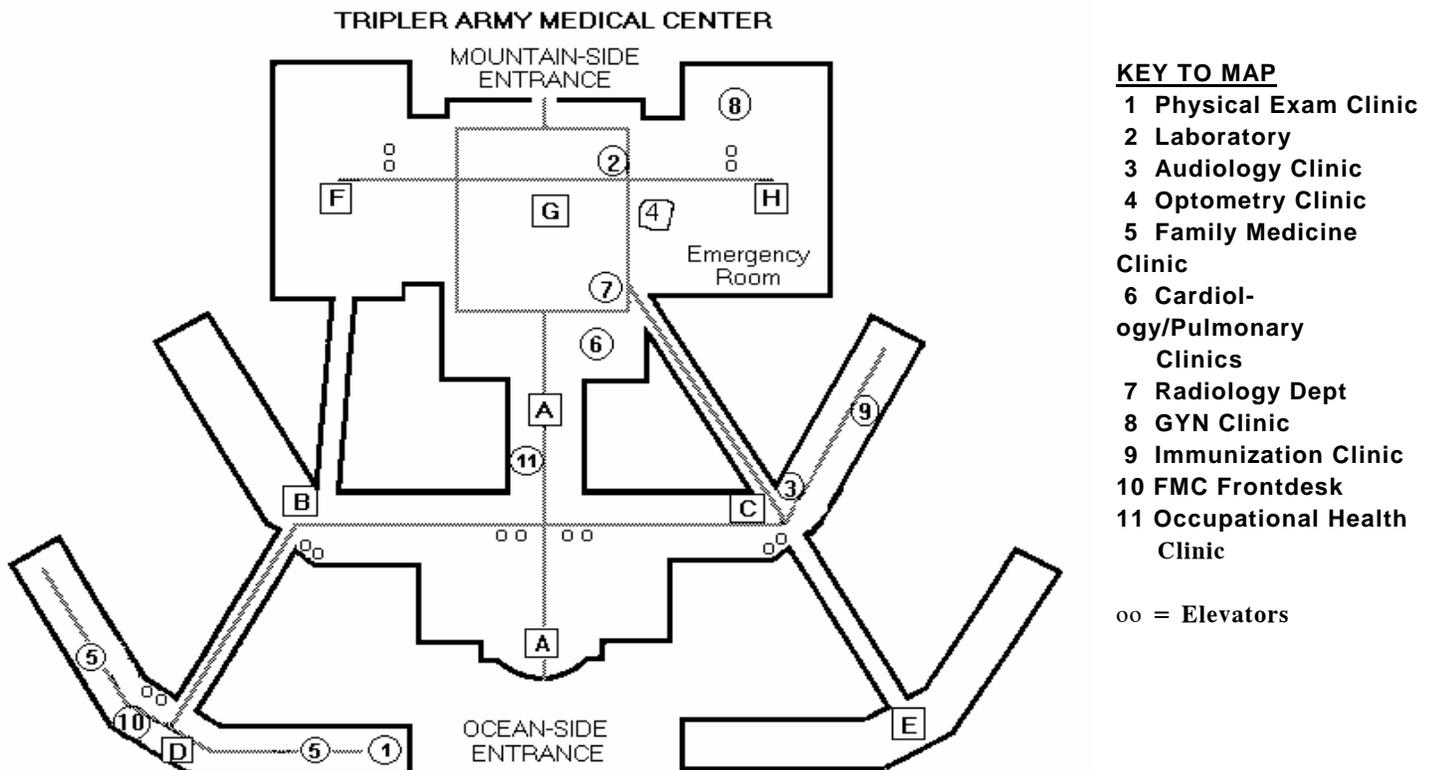
___ **FAMILY MEDICINE CLINIC** (height, weight, blood pressure, pulse) Wing D, 1st Floor.

___ **DENTAL CLINIC** (dental exam) Wing D, Ground Floor (G1). Times: Mon-Fri 0730-0900. Phone: 433-5370

___ **PULMONARY CLINIC** (PFT's) Wing A, 4th Floor (Rm.# 4A 308). Mon-Thur 1300-1500. Phone: 433-6627

___ **IMMUNIZATION CLINIC** (TB test) Wing C, 4th Floor. Times: Mon, Tues, Wed, Fri 0800-0900 Phone: 433-6334

___ **TREASURER'S OFFICE** (obtain authorization) Wing H, 3rd Floor. Phone: 433-6100



Instructions for completion of DD Form 2807-1, Report of Medical History

(Use black ballpoint pen if filling in by hand)

Item #

- 1 and 2 Self-explanatory
- 3 Today's Date – **LEAVE BLANK** (this will be filled in by the examiner when you return for Part II)
- 4a Current address, not "home of record"
- 4b Self-explanatory
- 5 **Leave blank** (this will be completed by the examiner)
- 6 to 9 Self-explanatory
- 10 – 28 Mark "YES" or "NO"
- 29 If any answer is "YES" (questions 10 to 28), write a brief summary of the problem including: 1) date(s) of illness, injury, surgery, etc.; 2) diagnosis, if known; 3) treatment (medication, physical therapy, etc.); and 4) current medical status.
- 30 **Leave blank** (this will be completed by the examiner)

Fill in **NAME** and **SOCIAL SECURITY NUMBER** at the top of pages 2 and 3

REPORT OF MEDICAL HISTORY
 (This information is for official and medically confidential use only
 and will not be released to unauthorized persons.)

OMB No. 0704-0413
 OMB approval expires
 Mar 31, 2010

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, Executive Services Directorate (0704-0413). 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 ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397 (SSAN).

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): None.

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 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. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE (YYYYMMDD)
4.a. HOME ADDRESS (<i>Street, Apartment No., City, State, and ZIP Code</i>)	5. EXAMINING LOCATION AND ADDRESS (<i>Include ZIP Code</i>) Physical Examination Clinic (MCHK-PE) Department of Family Medicine Tripler Army Medical Center 1 Jarrett White Road Honolulu, HI 96859-5000	
b. HOME TELEPHONE (<i>Include Area Code</i>)		

X ALL APPLICABLE BOXES:			7.a. POSITION (<i>Title, Grade, Component</i>)
6.a. SERVICE	6.b. COMPONENT	6.c. PURPOSE OF EXAMINATION	b. USUAL OCCUPATION
<input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	<input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	<input type="checkbox"/> Enlistment <input type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> Medical Board <input type="checkbox"/> Other (<i>Specify</i>) <input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program	

8. CURRENT MEDICATIONS (<i>Prescription and Over-the-counter</i>)	9. ALLERGIES (<i>Including insect bites/stings, foods, medicine or other substance</i>)
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Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	12. (Continued)	YES	NO
10.a. Tuberculosis	<input type="radio"/>	<input type="radio"/>	f. Foot trouble (<i>e.g., pain, corns, bunions, etc.</i>)	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input type="radio"/>	i. Knee trouble (<i>e.g., locking, giving out, pain or ligament injury, etc.</i>)	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input type="radio"/>	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input type="radio"/>
f. Bronchitis	<input type="radio"/>	<input type="radio"/>	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="radio"/>	<input type="radio"/>
g. Wheezing or problems with wheezing	<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
h. Been prescribed or used an inhaler	<input type="radio"/>	<input type="radio"/>	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (<i>cracked or fractured</i>)	<input type="radio"/>	<input type="radio"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (<i>liver disease</i>)	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>	e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>	g. Skin diseases (<i>e.g. acne, eczema, psoriasis, etc.</i>)	<input type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (<i>RK, PRK, LASIK, etc.</i>)	<input type="radio"/>	<input type="radio"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow or wrist (<i>e.g. pain, dislocation, etc.</i>)	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (<i>syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.</i>)	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>	c. Currently in good health (<i>If no, explain in Item 29 on Page 2.</i>)	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input type="radio"/>	d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input type="radio"/>

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:		YES	NO			YES	NO
15.a.	Dizziness or fainting spells	<input type="radio"/>	<input type="radio"/>	19.	Have you been refused employment or been unable to hold a job or stay in school because of:		
b.	Frequent or severe headache	<input type="radio"/>	<input type="radio"/>	a.	Sensitivity to chemicals, dust, sunlight, etc.	<input type="radio"/>	<input type="radio"/>
c.	A head injury, memory loss or amnesia	<input type="radio"/>	<input type="radio"/>	b.	Inability to perform certain motions	<input type="radio"/>	<input type="radio"/>
d.	Paralysis	<input type="radio"/>	<input type="radio"/>	c.	Inability to stand, sit, kneel, lie down, etc.	<input type="radio"/>	<input type="radio"/>
e.	Seizures, convulsions, epilepsy or fits	<input type="radio"/>	<input type="radio"/>	d.	Other medical reasons (If yes, give reasons.)	<input type="radio"/>	<input type="radio"/>
f.	Car, train, sea, or air sickness	<input type="radio"/>	<input type="radio"/>	20.	Have you ever been treated in an Emergency Room? (If yes, for what?)	<input type="radio"/>	<input type="radio"/>
g.	A period of unconsciousness or concussion	<input type="radio"/>	<input type="radio"/>	21.	Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	<input type="radio"/>	<input type="radio"/>
h.	Meningitis, encephalitis, or other neurological problems	<input type="radio"/>	<input type="radio"/>	22.	Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.)	<input type="radio"/>	<input type="radio"/>
16.a.	Rheumatic fever	<input type="radio"/>	<input type="radio"/>	23.	Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	<input type="radio"/>	<input type="radio"/>
b.	Prolonged bleeding (as after an injury or tooth extraction, etc.)	<input type="radio"/>	<input type="radio"/>	24.	Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)	<input type="radio"/>	<input type="radio"/>
c.	Pain or pressure in the chest	<input type="radio"/>	<input type="radio"/>	25.	Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.)	<input type="radio"/>	<input type="radio"/>
d.	Palpitation, pounding heart or abnormal heartbeat	<input type="radio"/>	<input type="radio"/>	26.	Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)	<input type="radio"/>	<input type="radio"/>
e.	Heart trouble or murmur	<input type="radio"/>	<input type="radio"/>	27.	Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.)	<input type="radio"/>	<input type="radio"/>
f.	High or low blood pressure	<input type="radio"/>	<input type="radio"/>	28.	Have you ever been denied life insurance?	<input type="radio"/>	<input type="radio"/>
17.a.	Nervous trouble of any sort (anxiety or panic attacks)	<input type="radio"/>	<input type="radio"/>	29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)			
b.	Habitual stammering or stuttering	<input type="radio"/>	<input type="radio"/>				
c.	Loss of memory or amnesia, or neurological symptoms	<input type="radio"/>	<input type="radio"/>				
d.	Frequent trouble sleeping	<input type="radio"/>	<input type="radio"/>				
e.	Received counseling of any type	<input type="radio"/>	<input type="radio"/>				
f.	Depression or excessive worry	<input type="radio"/>	<input type="radio"/>				
g.	Been evaluated or treated for a mental condition	<input type="radio"/>	<input type="radio"/>				
h.	Attempted suicide	<input type="radio"/>	<input type="radio"/>				
i.	Used illegal drugs or abused prescription drugs	<input type="radio"/>	<input type="radio"/>				
18.	FEMALES ONLY. Have you ever had or do you now have:						
a.	Treatment for a gynecological (female) disorder	<input type="radio"/>	<input type="radio"/>				
b.	A change of menstrual pattern	<input type="radio"/>	<input type="radio"/>				
c.	Any abnormal PAP smears	<input type="radio"/>	<input type="radio"/>				
d.	First day of last menstrual period (YYYYMMDD)						
e.	Date of last PAP smear (YYYYMMDD)						

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)

SOCIAL SECURITY NUMBER

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*

c. SIGNATURE

d. DATE SIGNED
(YYYYMMDD)

Instructions for completion of DD Form 2808, Report of Medical Examination

(Use black ballpoint pen if filling in by hand)

- | <u>Item #</u> | |
|---------------|---|
| 1 | Date of Examination – LEAVE BLANK (this will be filled in by the examiner when you return for Part II) |
| 2 and 3 | Self-explanatory |
| 4 | Current address, not “home of record” |
| 5 to 11 | Self-explanatory |
| 12 | Agency (Non-Service Members Only) – Peace Corps, U.S. State Dept, NOAA, etc. |
| 13 | Self-explanatory |
| 14a to 14c | Leave blank (for aviators only) |
| 15a to 15c | Self-explanatory |
| 16 to 86 | Leave blank to be filled in by examiner |

Fill in **NAME** and **SOCIAL SECURITY NUMBER** at the top of pages 2 and 3

REPORT OF MEDICAL EXAMINATION	1. DATE OF EXAMINATION (YYYYMMDD)	2. SOCIAL SECURITY NUMBER
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PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.

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): None.

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.

3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code)	5. HOME TELEPHONE NUMBER (Include Area Code)
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6. GRADE	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	10.a. RACIAL CATEGORY (X one or more) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	b. ETHNIC CATEGORY <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino
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11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY b. CIVILIAN	12. AGENCY (Non-Service Members Only)	13. ORGANIZATION UNIT AND UIC/CODE
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14.a. RATING OR SPECIALTY (Aviators Only)	b. TOTAL FLYING TIME	c. LAST SIX MONTHS
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15.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> ROTC Scholarship Program	16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include ZIP Code) Physical Examination Clinic (MCHK-PE) Department of Family Medicine, Tripler AMC 1 Jarrett White Road Honolulu, HI 96859-5000
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CLINICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.)

	Nor- mal	Ab- norm	NE	44. NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)
17. Head, face, neck, and scalp				
18. Nose				
19. Sinuses				
20. Mouth and throat				
21. Ears - General (Int. and ext. canals/Auditory acuity under item 71)				
22. Drums (Perforation)				
23. Eyes - General (Visual acuity and refraction under items 61 - 63)				
24. Ophthalmoscopic				
25. Pupils (Equality and reaction)				
26. Ocular motility (Associated parallel movements, nystagmus)				
27. Heart (Thrust, size, rhythm, sounds)				
28. Lungs and chest (Include breasts)				
29. Vascular system (Varicosities, etc.)				
30. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)				
31. Abdomen and viscera (Include hernia)				
32. External genitalia (Genitourinary)				
33. Upper extremities				
34. Lower extremities (Except feet)				
35. Feet (See Item 35 Continued)				
36. Spine, other musculoskeletal				
37. Identifying body marks, scars, tattoos				
38. Skin, lymphatics				
39. Neurologic				
40. Psychiatric (Specify any personality deviation)				
41. Pelvic (Females only)				
42. Endocrine				

43. DENTAL DEFECTS AND DISEASE (Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in Item 44.) <input type="checkbox"/> Acceptable <input type="checkbox"/> Not Acceptable Class _____	35. FEET (Continued) (Circle category) Normal Arch Mild Asymptomatic Pes Cavus Moderate Pes Planus Severe Symptomatic
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LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
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LABORATORY FINDINGS				
45. URINALYSIS	a. Albumin	46. URINE HCG	47. H/H	48. BLOOD TYPE
	b. Sugar			
TESTS	RESULTS	HIV SPECIMEN ID LABEL		DRUG TEST SPECIMEN ID LABEL
49. HIV				
50. DRUGS				
51. ALCOHOL				
52. OTHER				
a. PAP SMEAR				
b. Urine Micro				
c.				

MEASUREMENTS AND OTHER FINDINGS															
53. HEIGHT	54. WEIGHT	55. MIN WGT - MAX WGT			MAX BF %			56. TEMPERATURE	57. PULSE						
	lbs.														
58. BLOOD PRESSURE				59. RED/GREEN (Army Only)			60. OTHER VISION TEST								
a. 1ST	b. 2ND	c. 3RD													
SYS.	SYS.	SYS.													
DIAS.	DIAS.	DIAS.													
61. DISTANT VISION			62. REFRACTION BY AUTOREFRACTION OR MANIFEST				63. NEAR VISION								
Right 20/	Corr. to 20/		By	S.	CX		Right 20/	Corr. to 20/ by							
Left 20/	Corr. to 20/		By	S.	CX		Left 20/	Corr. to 20/ by							
64. HETEROPHORIA (Specify distance)															
ES°	EX°	R.H.	L.H.	Prism div.	Prism Conv	CT		NPR	PD						
65. ACCOMMODATION			66. COLOR VISION (Test used and result)			67. DEPTH PERCEPTION (Test used and score) AFVT									
Right	Left		PIP			/14		Uncorrected		Corrected					
68. FIELD OF VISION				69. NIGHT VISION (Test used and score)				70. INTRAOCULAR TENSION							
								O.D.	O.S.						
71a. AUDIOMETER		Unit Serial Number					71b. Unit Serial Number					72a. READING ALOUD			
		Date Calibrated (YYYYMMDD)					Date Calibrated (YYYYMMDD)					TEST			
HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000	<input type="checkbox"/> SAT	<input type="checkbox"/> UNSAT
Right							Right							72b. VALSALVA	
Left							Left							<input type="checkbox"/> SAT	<input type="checkbox"/> UNSAT

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY (Use additional sheets if necessary.)

HDL: _____ LDL: _____ TG: _____ CHOL: _____ FBS: _____ RPR: _____ G6PD: _____

WBC: _____ Hgb: _____ Hct: _____ PSA: _____ Sickle Cell: _____ Anti-HCV: _____

Occult Blood: _____

SMOKING HISTORY:

_____ Never smoked Ex-smoker; quit how long ago? _____

_____ Current smoker; number of cigarettes per day: _____ Cigar smoker; number of cigars per day: _____

EKG: _____

Chest X-rays: _____

PATIENT INSTRUCTIONS FOR HIV (AIDS VIRUS) TESTING

1. The Army has a program to routinely screen patients for infection with Human Immunodeficiency Virus (HIV), the virus which causes Acquired Immune Deficiency Syndrome (AIDS). Routine testing assists physicians and other health care providers in being fully aware of a patient's health status. A person who is infected with HIV could have adverse reactions to certain treatments. Additionally, early identification of infected patients may help to prevent the spread of infection.

2. HIV screening is mandatory for active duty (AD) military members. AD military members will have their blood drawn and tested for HIV unless there is military documentation of a test result in the previous twelve months.

3. The HIV screening test is voluntary for non-active duty patients. These patients have the right to refuse this test.

4. No patient who declines to be tested for HIV will be denied appropriate care.

5. The screening test for HIV requires that a blood sample be obtained using a needle.

6. The blood sample is tested for evidence of HIV infection. A positive test does not mean that one has, or will develop the disease AIDS.

7. A **NEGATIVE TEST** means that no evidence of HIV has been detected in your blood. There are two possible explanations for this:

- You have not been infected by the virus.
- Or you have recently been infected by HIV and are capable of transmitting the virus to others, but your blood test has not yet become positive.

NOTE: It may take as long as three weeks to get the results of a negative test.

8. A **POSITIVE TEST** means that:

- You have been infected with HIV.
- You can pass the virus on to others by having sex, sharing needles, becoming pregnant, or donating blood or organs.

9. If your test is positive you will be notified by your doctor and will receive additional medical evaluation, counseling and treatment as indicated.

10. The results of a positive HIV test will be placed in your medical record and appropriate persons involved in health care will have access to that information. The results of the HIV antibody test are considered confidential and shall not be released without your

written permission, except to the individuals and organizations who are authorized access under state and federal laws or regulations.

11. For more health care information visit Tripler's Health Education Center located on the 1st floor, ocean side entrance, next to the Community Library in Room 1A-001. Hours of operations are Monday thru Friday 0900 – 1700 and Saturday 1100 – 1500. For more information, call 433-2176/2565.

CONSENT FOR HIV (AIDS VIRUS) TESTING
(Patient Medical Record Copy)

I have been counseled and given written information concerning HIV testing and understand the content. I have also been given the opportunity to ask questions.

_____ Yes, I agree to have my blood tested for HIV.

_____ No, I decline to have my blood tested for HIV.

Signature _____

Date _____

Printed Name _____

=====

SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent)

I, _____ sponsor/guardian of

_____ agree to / decline HIV testing.
(circle choice)

Signature _____

Date _____

Printed Name _____

=====

HEALTH CARE PROVIDER

I have counseled _____ concerning HIV testing.

Signature _____

Date _____

Printed Name _____