REPORT OF MEDICAL ASSESSMENT

PRIVACY ACT STATEMENT

AUTHORITY: PL 103-160, EO 9397.
PRINCIPAL PURPOSE: To be used by the Medical Services to provide a comprehensive medical assessment for active and reserve component service members separating or retiring from active duty.
ROUTINE USES: A copy of this form will be released to the Department of Veterans Affairs.
DISCLOSURE: Voluntary; however, failure to disclose the requested personal information may result in delay in processing any disability claim.

SECTION I - TO BE COMPLETED BY SERVICE MEMBER. Any service member who requests a physical examination may have one.

1. NAME *(Last, First, Middle)*	2. SOCIAL SECURITY NUMBER	3. RANK

4. COMPONENT	5. UNIT OF ASSIGNMENT

6a. HOME STREET ADDRESS *(Or RFD, including apartment number)*	b. CITY	c. STATE	d. ZIP CODE	7. HOME TELEPHONE NUMBER *(Include area code)*

8. DATE OF LAST PHYSICAL EXAMINATION BY THE MILITARY *(YYMMDD)*	9. DATE ENTERED ON CURRENT ACTIVE DUTY *(YYMMDD)*

10. COMPARED TO MY LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, MY OVERALL HEALTH IS *(X one. If "Worse," explain.)*

- ☐ **THE SAME**
- ☐ **BETTER**
- ☐ **WORSE**

11. SINCE YOUR LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, HAVE YOU HAD ANY ILLNESSES OR INJURIES THAT CAUSED YOU TO MISS DUTY FOR LONGER THAN 3 DAYS? *(X one. If "Yes," explain.)*

- ☐ **NO**
- ☐ **YES**

12. SINCE YOUR LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, HAVE YOU BEEN SEEN BY OR BEEN TREATED BY A HEALTH CARE PROVIDER, ADMITTED TO A HOSPITAL, OR HAD SURGERY? *(X one. If "Yes," explain.)*

- ☐ **NO**
- ☐ **YES**

13. HAVE YOU SUFFERED FROM ANY INJURY OR ILLNESS WHILE ON ACTIVE DUTY FOR WHICH YOU DID NOT SEEK MEDICAL CARE? *(X one. If "Yes," explain.)*

- ☐ **NO**
- ☐ **YES**

14. ARE YOU NOW TAKING ANY MEDICATIONS? *(X one. If "Yes," list medications.)*

- ☐ **NO**
- ☐ **YES**

15. DO YOU HAVE ANY CONDITIONS WHICH CURRENTLY LIMIT YOUR ABILITY TO WORK IN YOUR PRIMARY MILITARY SPECIALTY OR REQUIRE GEOGRAPHIC OR ASSIGNMENT LIMITATIONS? (*X one. If "Yes," explain.)*

- ☐ **NO**
- ☐ **YES**

16. DO YOU HAVE ANY DENTAL PROBLEMS? *(X one. If "Yes," explain.)*

- ☐ **NO**
- ☐ **YES**

17. DO YOU HAVE ANY OTHER QUESTIONS OR CONCERN ABOUT YOUR HEALTH? *(X one. If "Yes," explain.)*

- ☐ **NO**
- ☐ **YES**

18. AT THE PRESENT TIME, DO YOU INTEND TO SEEK DEPARTMENT OF VETERANS AFFAIRS (VA) DISABILITY? *(X one. If "Yes," list conditions for which you will ask for VA Disability.)*

- ☐ **NO**
- ☐ **YES**
- ☐ **UNCERTAIN**

19. CERTIFICATION. I certify that the information provided above is true and complete to the best of my knowledge.

a. SIGNATURE OF SERVICE MEMBER	b. DATE SIGNED *(YYMMDD)*

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SECTION II - TO BE COMPLETED BY INDIVIDUALLY PRIVILEGED HEALTH CARE PROVIDER

This Report of Medical Assessment is to be used by the Medical Services to provide a comprehensive medical assessment for active and reserve component service members separating or retiring from active duty. The assessment will cover, as a minimum, the period since the service member's last medical assessment/physical examination, or the period of this call or order to active duty. Any service member who requests a physical examination may have one. Any service member who has indicated "yes" to Item 18 will have an appropriate physical examination, if the last examination is more than 12 months old and/or there are new signs and/or symptoms. If the service member answers "Worse" to Item 10 or "Yes" to Items 11, 12, or 14 through 18, documentation of the injury, illness, or problem should be included in the service member's medical or dental record.

20. HEALTH CARE PROVIDER COMMENTS *(All patient complaints must be addressed)*

21. WAS PATIENT REFERRED FOR FURTHER EVALUATION? *(X one. If "Yes," specify where.)*

☐ **NO**

☐ **YES**

22. PURPOSE OF ASSESSMENT *(X one. If "Other," explain.)*

☐ **SEPARATION** *(Includes discharge from military service and release from active duty, including release of National Guard and Reserve personnel voluntarily or involuntarily called or ordered to active duty.)*

☐ **RETIREMENT**

☐ **OTHER**

23. MEDICAL FACILITY	**24. DATE OF ASSESSMENT** *(YYMMDD)*

25. HEALTH CARE PROVIDER

a. NAME *(Last, First, Middle)*	**b. GRADE/RANK**	**c. SIGNATURE**

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