Abbreviated Report of Medical Examination for JROTC Instructors

PART I – GENERAL INFORMATION

Last Name:	First Name:		Middle Name:
SSN:	Date of Birth:	Age:	Date of Examination:
Mailing Address (Include zip code):		Emergency Contact (Name, address, telephone):	
Reason for Military Discharge: Retired ☐ Medical ☐		Height	Weight	BFP *(if applicable, include body fat worksheet)*:
Name of Examining Facility (Complete Address):		Name of Examiner:	

PART II – CLINICAL EVALUATION

(Please mark the appropriate column)

	Normal	Abnormal		Normal	Abnormal
a. BP 1. Sitting 2. Standing:			h. Rectal examination		
b. Pulse			i. Hearing		
c. Neurological			j. Psychiatry *(specify and personality deviation)*		
d. Auscultation of the heart			k. Eye *(acuity, refraction, intraocular, pressure)*		
e. Breast examination			l. Extremities *(Upper/Lower)*		
f. Inguinal hernia check			m. Spine *(Alignment)*		
g. Pap smear *(female)*					

Have you received a disability rating from the Veterans Affairs? Yes ☐ No ☐
(Please submit the most recent completed VA evaluation)

Percentage of Disability (circle)	**10%**	**20%**
	30%	**40%**
	50%	**60%**
	70%	**80%**
	90%	**100%**

PART III – MEDICAL HISTORY (If you answer yes to any of the questions below explain in detail in the Remarks section)	YES	NO
a. Do you take any medications regularly?		
b. Do you have frequent, severe, or migraine headaches?		
c. Do you experience fainting or dizzy spells?		
d. Do you have epilepsy, seizures or convulsions?		
e. Do you experience depression, anxiety, excessive worry or nervousness?		
f. Do any mental conditions or illnesses exist?		
g. Do you have frequent trouble sleeping?		
h. Are you asthmatic or do you have breathing irregularities?		
i. Have you ever had a heart attack, stroke or murmur?		
j. Do you have bone or joint problems/injuries that required surgery or continuing medical treatment?		
k. Do you have a history of high blood pressure?		
l. Do you have a history of diabetes?		
m. Have you experienced pain or pressure in the chest?		
n. Do you experience back pain or had trouble with your back in the past?		
o. Do you suffer from paralysis or weakness in any of your extremities?		
p. Do you have tuberculosis or ever had a positive TB time test?		
q. Do you have or ever had a tumor, growth, cyst or been diagnosed with cancer?		
u. Have you ever contemplated or attempted suicide?		
r. Have you received or applied for pension or compensation for an existing disability?		
s. Have you had any major illnesses or injuries other than those already noted?		

PART V – REMARKS

(Use this section to provide details or explain any illness or medical problems. Use a continuation sheet if necessary)

Name of Examiner *(Last, First, Middle Initial)*	Signature	Duty Title	Date