# 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<br>(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 |
|---|---|---|---|
| | | | |