REPORT OF MEDICAL EXAMINATION

1. DATE OF EXAMINATION (YYYYMMDD)	2a. SOCIAL SECURITY NUMBER	2b. DoD ID NUMBER (If applicable)
		1043275387

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 504, Persons not qualified; 10 U.S.C. 505, Regular components: qualifications, term, grade; 10 U.S.C. 507, Extension of enlistment for members needing medical care or hospitalization; 10 U.S.C. 532, Qualifications for original appointment as a commissioned officer; 10 U.S.C. 978, Drug and alcohol abuse and dependency: testing of new entrants; 10 U.S.C. 1201, Regulars and members on active duty for more than 30 days: retirement; 10 U.S.C. 1202, Regulars and members on active duty for more than 30 days: temporary disability retired list; 10 U.S.C. 4346, Cadets: requirements for admission; DoD Directive 1145.2, United States Military Entrance Processing Command; E.O. 9397 (SSN) and 10 U.S.C. 1204, Members on Active Duty for 30 Days or Less or on Inactive Duty Training: Retirement, as amended.

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): The Routine Uses are listed in the applicable system of records notice found at: http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570681/a0601-270-usarpac-dad/

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)	5a. HOME TELEPHONE NUMBER (Include Area Code)	5b. E-MAIL ADDRESS
Sweeney, Robert, F, III	2904 Eastover North Dr. Fayetteville, NC 28312	(979) 220-8698	robert.f.sweeney.mil@socom.mil

6. GRADE/ RANK	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9a. BIRTH SEX	9b. PREFERRED GENDER	10a. ETHNIC CATEGORY	10b. RACIAL CATEGORY (Select one)
CPT/O3	19820807	41	☑ Male ☐ Female	☑ Male ☐ Female	☐ Hispanic/Latino ☑ Non Hispanic/Latino	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☑ White ☐ Native Hawaiian or Other Pacific Islander

11. TOTAL YEARS GOVERNMENT SERVICE		12. AGENCY (Non-Service Members Only)	13. ORGANIZATION UNIT AND UIC/CODE
a. MILITARY	b. CIVILIAN		
15			6 BN, 2 SWTG(A) / W1E0HU

14a. RATING OR SPECIALTY (Aviators Only)	14b. TOTAL FLYING TIME	14c. LAST SIX MONTHS

15a. SERVICE	15b. COMPONENT	15c. PURPOSE OF EXAMINATION		16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include Zip Code)
☑ Army ☐ Air Force ☐ Marine Corps ☐ Navy ☐ Coast Guard	☑ Active Duty ☐ Reserve ☐ National Guard	☐ Enlistment ☐ Commission ☐ Retention ☐ Separation ☑ Other SFAS/Airborne	☐ Retirement ☐ U.S. Service Academy ☐ ROTC Scholarship Program ☐ Medical Board	2nd Special Warfare Training Group (Airborne) Clark Health Clinic 5-4257 Bastogne Dr, Fort Bragg, NC 28310

MEDICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.)

	Normal	Abnormal	NE
17. Head, face, neck and scalp	☑	☐	☐
18. Nose	☑	☐	☐
19. Sinuses	☑	☐	☐
20. Mouth and throat	☑	☐	☐
21. Ears - General (Int. and ext. canals/Auditory acuity under separate entry)	☑	☐	☐
22. Tympanic Membranes (Perforation)	☑	☐	☐
23. Eyes - General	☑	☐	☐
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 (Check category)	☑	☐	☐
35a. ☑ Normal Arch ☐ Pes Planus ☐ Pes Cavus			
35b. ☐ Mild ☐ Moderate ☐ Severe			
35c. ☑ Asymptomatic ☐ Symptomatic ☐ Rigid			
36. Spine, other musculoskeletal	☑	☐	☐
37. Body marks, scars, tattoos	☑	☑	☐
38. Skin, lymphatics	☑	☐	☐
39. Neurologic	☑	☐	☐
40. Psychiatric (Specify any personality disorder)	☑	☐	☐
41. Pelvic (Females only)	☐	☐	☒
42. Endocrine	☑	☐	☐

43. DENTAL DEFECTS AND DISEASE (Please explain. Use dental form if completed by dentist. If abnormality noted, explain in item 44.)

Acceptable ☒ Not Acceptable ☐ Class 1

44. NOTES: (Mandatory comment for every abnormality identified in items 17 - 43. Enter pertinent item number before each comment. Continue comments or use drawings in item 89 and use additional sheets if necessary.)

37. Tattoo (R) shoulder

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LABORATORY FINDINGS

45. URINALYSIS	a. Albumin	b. Sugar	46. URINE HCG	47. H/H	48. BLOOD TYPE
1.026	1+	Neg		14.9/42.9	O+

TESTS	RESULTS	HIV SPECIMEN ID LABEL	DRUG TEST SPECIMEN ID LABEL
49. HIV	Neg		
50. DRUGS			
51. ALCOHOL			
52. OTHER			
a. PAP SMEAR			
b. EKG	WNL } see attached		
c. CXR	WNL }		

MEASUREMENTS AND OTHER FINDINGS

53. HEIGHT (in.)	54. WEIGHT (lbs.)	55a. MIN WGT	55b. MAX WGT	55c. MAX BF %	55d. BMI	56. TEMPERATURE	57. HEART RATE
68	179						72

58. BLOOD PRESSURE			59. RED/GREEN	60. OTHER VISION TEST
a. 1ST	b. 2ND	c. 3RD	VIVID RED / GREEN	Womack Army Medical Center
SYS. 128	SYS.	SYS.	PASS FAIL	Bldg 4-2817 Rock Merritt Ave
DIAS. 90	DIAS.	DIAS.		Department of Optometry
				Main Phone: 910-643-2020
				Fort Liberty, NC 28310

61. DISTANCE VISION		62. REFRACTION ☐ AUTO ☑ MANIFEST ☐ CYCLO			63. NEAR VISION		
Right Uncorr. 20/ 20	Corr. to 20/ 20	Sph: -0.25	Cyl: -0.25	Axis: 015	Right Uncorr. 20/ 20	Corr. to 20/ 20	Add: N/A
Left Uncorr. 20/ 20	Corr. to 20/ 20	Sph: -0.25	Cyl: -0.50	Axis: 175	Left Uncorr. 20/ 20	Corr. to 20/ 20	Add:

64. HETEROPHORIA							
ES	EX	R.H.	L.H.	Prism div.	Prism Conv CT	NPR	PD

65. ACCOMMODATION		66. COLOR VISION (Pass/Fail and Score)			67. DEPTH PERCEPTION (Pass/Fail and Score)	
Right	Left	PIP 14/14 ✓	RED/ GREEN PASS	Color Dx	AFVT	RANDOT/ MCST

68. FIELD OF VISION	69. NIGHT VISION	70. INTRAOCULAR PRESSURE	
FTC OD / FTC OS	NIBH	O.D. 11	O.S. 13

71a. AUDIOMETER Unit Serial Number	71b. Unit Serial Number	72a. READING ALOUD TEST:	☐ SAT	☐ UNSAT
Date Calibrated (YYYYMMDD)	Date Calibrated (YYYYMMDD)	72b. VALSALVA:	☒ SAT	☐ UNSAT

HZ	500	1000	2000	3000	4000	6000
Left	0	0	0	0	0	0
Right	5	0	-5	0	5	10

HZ	500	1000	2000	3000	4000	6000
Left						
Right						

72c. OTHER TESTING

73. NOTES AND/OR INTERVAL HISTORY

WBC 5.1
Platelets 201

Sickle Cell Neg 2 APR24
G6PD WNL 2APR24

Fecal Occult Neg

Cholesterol:
Tot 242
LDL 165
HDL 62
Tri 172
2APR24

PPD Neg 11APR24

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74. EXAMINEE
- [x] IS MEDICALLY QUALIFIED for SFAS/ABN
- [ ] IS NOT MEDICALLY QUALIFIED

76. I have been advised of my disqualifying condition(s).

76a. SIGNATURE OF EXAMINEE

76b. DATE (YYYYMMDD)

75. PHYSICAL PROFILE

P	U	L	H	E	S	X	D	PROFILER INITIALS	
1	1	1	1	1	1	A		JAH	

77. SIGNIFICANT OR DISQUALIFYING MEDICAL DIAGNOSES

ITEM NO.	MEDICAL DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE (YYYYMMDD)	QUALIFIED	DISQUALIFIED	EXAMINER INITIALS	WAIVER RECEIVED	
								SERVICE	DATE (YYYYMMDD)

78. SUMMARY OF MEDICAL DIAGNOSES (List diagnoses with item numbers) (Use additional sheets if necessary).
- Proteinuria - treated with lisinopril 20 mg daily. Cleared by Nephro. Waiver approved for COCHISE FF.
- Hyperlipidemia
- spondylolisthesis - s/p TLIF. Much improved condition. Currently asymptomatic. No profiles/duty limitations.

79. RECOMMENDATIONS (Specify) (Use additional sheets if necessary).

Qualified for SFAS/ABN.

80. MEPS WORKLOAD (For MEPS use only)

WKID	ST	DATE (YYYYMMDD)	INITIALS	WKID	ST	DATE (YYYYMMDD)	INITIALS

81. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	EXAMINER'S NAME AND SIGNATURE

82a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER
CPT James A. Harter MD, FS

82b. Signature [signature] MD, FS

JAMES A. HARTER, M.D.
CPT, MC
Family Medicine NPI: 1720

83a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER

83b. Signature

84a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)
RACHEL DUVAL MAJ, DC SFSHOC

84b. Signature [signature] SFSS, SFSHOC

85a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY (Indicate which)

85b. Signature

86. This examination has been administratively reviewed for completeness and accuracy.

a. SIGNATURE	b. GRADE	c. DATE (YYYYMMDD)

87. WAIVER GRANTED (If yes, date and by whom)	YES ☐	NO ☐	88. NUMBER OF ATTACHED SHEETS

89. ADDITIONAL REMARKS

JAMES A. HARTER, M.D.
CPT, MC
Family Medicine