Commissioned Corps of the U.S. Public Health Service

General Instructions for Completing Medical Examination Forms DD-2807-1 "Report of Medical History" and DD-2808 "Report of Medical Examination"

Forms are available at https://dcp.psc.gov/ccmis/forms/FORMS_medical_m.aspx and are used for medical examinations intended for the purposes of Retention, Assimilation, Retirement/Separation, Long Term Training, Limited Tour Removal, and other medical information reporting purposes. **Failure to complete the forms according to these instructions will delay your medical clearance.**

A **complete physical examination** is required every five years. Each five-year periodic physical exam is valid through the end of the month from the date signed by the examiner. Thus, if you completed your medical examination in June of 2015, your medical clearance expires June 30, 2020.

A complete physical exam consists of:

DD-2807-1 "Report of Medical History",
DD-2808 "Report of Medical Examination",
PHS-6355 "Applicant Dental Exam Form" (per instructions #43),
Reports of all lab and screening tests, including ECGs, audiograms, etc.,
Other pertinent medical documents-age related, and
Disclosure Statement

All of these documents including the Disclosure Statement must be completed per the instructions below and scanned into **one** PDF file which must be uploaded through the medical e-DOC-U portal located in the Officer Secure Area of the CCMIS website, https://dcp.psc.gov/ccmis/:

1. Once in the Officer Secure Area, select eDOC-U (Document Upload).
2. Select "Medical" from the Document Category dropdown.
3. Select "PHYSICAL EXAM DOCUMENTS" for Document Type.
4. For the Document Date use the date that the provider signed the document. For those officers who got their physical at an MTF that splits the process into part, enter the date when the first part was completed.

DO NOT UPLOAD ANY 5-YEAR PHYSICAL FORMS OR ASSOCIATED REPORTS THROUGH ANY PORTAL OTHER THAN "PHYSICAL EXAM DOCUMENTS."

Current DD-2807-1 "**Report of Medical History**" no older than one year will be required for Assimilation, Permanent Promotion, Long Term Training, or to inform Medical Affairs of a new medical condition.

To submit an updated medical history which is not part of a 5-year physical exam, upload the DD-2807-1 with a Disclosure Statement using Document Type, "REPORT OF MEDICAL HISTORY (ANNUAL)".

Always keep copies for your records. Make sure that all forms are dated and your Name and PHS SERNO is on ALL documents uploaded through eDOC-U.

Uploaded copies must be legible; illegible records will be rejected.

MAILED COPIES AND FAXES WILL NOT BE ACCEPTED

Required Disclosure Statement
And
Instructions Statement of Understanding

I certify that I have reviewed the foregoing information and that it is true and complete to the best of my knowledge. I understand that falsification of information on the DD-2807-1 "Report of Medical History" and other Government forms is punishable by disqualification, separation, fine and/or imprisonment. My signature on this document **also indicates that I have read and followed the instructions for completion of the physical exam forms: DD-2808 and DD-2807-1**. I understand that submission of an incomplete history or physical exam will result in the delay of the review of my physical exam and that the forms will be rejected. My medical history is required to be on the DD-2807-1 "Report of Medical History" and my physical exam is required to be on the DD-2808 "Report of Medical Examination". Both should be completed according to the instructions on the following pages.

Officer's Signature _____ PHS SERNO _____

Printed Name _____ Date _____

This form **must** be **signed (electronic signature accepted), dated**, and scanned with all other required forms and supporting documents into a single PDF. This form must accompany all 5-year physical examination and medical history update documents and **uploaded through the appropriate medical section of eDOC-U.**

Mailed and faxed copies will NOT be accepted.

Instructions for Completing DD-2807-1
"Report of Medical History"

Items 1 through 5 on page 1 of the form MUST be completed including information on the top of page 2 and 3:

Last Name, **First** Name, **Middle** Name and USPHS Service Number **(SERNO) in place of Social Security Number** (enter as 0000+SERNO: 000012345 if typing the form online).

1. **Last** Name, **First** Name, **Middle** Name
2. **Social Security Number**-*must* be entered as SERNO (enter as 0000+SERNO if typing the form online. Example: 000012345).
3. **TODAY'S date**-use **YYYY-MM-DD** numerical format
4. a. **Home addresses**
   b. **Home telephone** (include area code);
5. **Examining Location and Address**
6. a. **Service**-*write in* "USPHS"
   b. **Component**-"Active Duty"
   c. **Purpose of Examination:** you may check one or more of the choices listed in this section, e.g.:
      Retention (a.k.a. 5 yr PE)
      Separation
      Retirement (and **add**: "Length of Service", "Temporary", or "Age")
   OR check the box "Other" and write in:
      Assimilation
      Permanent Promotion
      5-year Periodic Physical Long-term
      Training Fitness for Duty
      Limited Tour Re-evaluation
7. a. **Position**-your rank
   b. **Usual Occupation**-category
8. **Current Medications**-list all medications you currently take
9. **Allergies**-medication and non-medication allergies
10. **HAVE YOU EVER HAD OR DO YOU NOW HAVE**
    Answer YES or NO to items 10 through 28, **(If your response to question 14c is "No", please provide explanation.) -*REMEMBER*** *the question asks, "Have You Ever Had or do You Now Have"*
29. **Explanation of "YES" answer**(s)
    Describe in detail all yes answer(s); give date(s) of problem(s), name(s) of doctor(s) and/or hospital(s), treatment(s) given, current medical status, and limitations.
30. **<u>Examiner's Summary and Elaboration of All Pertinent Data REQUIRED</u> <u>For 5 Year Physical.</u>** optional for all other. Complete as described in this section.
    a. **Comments**-of examining provider
    b. **Typed or Printed Name of Examiner**-Last, First, Middle Initial
    c. **Signature**-of provider
    d. **DATE SIGNED**-YYYY-MM-DD format

THIS DOCUMENT IS INCOMPLETE IF LEFT UNDATED

Instructions for Completing DD-2808
"Report of Medical Examination"

Items 1 through 10a, 15 to 16, and information at the top of page 2 and 3 MUST be provided.
Items 10b through 14c are optional.

Last Name, **First** Name, **Middle** Name and USPHS Service Number (SERNO) in place of Social Security Number (enter as 0000+SERNO: 000012345 if typing the form online).

1. **Date of Examination**-use YYYY-MM-DD numerical format
2. **Social security number**- *must* be entered as SERNO (enter as 0000 +SERNO if typing the form online. Example: 000012345).
3. **Last** name-**First** name-**Middle** name (suffix)
4. **Home Address**-*required*
5. **Home Telephone Number** (include area code)
6. **Grade**-rank
7. **Date of Birth**-use YYYY-MM-DD numerical format
8. **Age**
9. **Sex**-check female or male
10. a. **Racial Category**-this is needed for **medical** purposes only
    b. **Ethnic Category**-optional
11. a. and b. **Total years government service**-optional
12. **Agency**-IHS, CDC, BOP, NIH, etc.
13. **Organization Unit and UIC/Code**-leave blank
14. a. **Rating or Specialty**
    b. **Total Flying Time**
    c. **Last six months**-leave 14a-c blank, unless you are an Aviator
15. a. **Service**-*write in* "USPHS"
    b. **Component**-"Active Duty"
    c. **Purpose of Examination:** Check one or more of the choices listed in this section, e.g.:
        Retention (a.k.a. 5 yr PE)
        Separation
        Retirement (and **add**: "Length of Service", "Temporary", or "Age")
        OR check the box "Other" and write in:
            Assimilation
            Permanent Promotion
            CCRF
            Long-term Training
            Fitness for Duty
            Limited Tour Re-evaluation
16. **Name of Examining Location, and Address** (include ZIP Code)

Clinical Evaluation section

17 through 42 **and** number 35 [**Feet (continued)]**
This section is to be completed by your provider(s). More than one provider may use this section.

44. **Notes**-provider(s) should follow the instructions in this section.

The Clinical Evaluation ***must*** include**:**

- Rectal exam with fecal occult blood testing (FOBT) x 3 for colorectal cancer screening. (≥ age 40)
- Flexible-sigmoidoscopy or colonoscopy (≥age 50 is **required**)
- **Copy** of recent EKG (within last 12 months) with interpretation (>age 40)-**required**
- Chest X-ray-required for everyone with a positive PPD along with documentation of any prophylactic treatment and written request for a PPD waiver in accordance with "Manual Circular 377"; otherwise optional or as clinically indicated
- Pulmonary Function Test-as clinically indicated

Additional tests/exams for Males:

- PSA (≥ age 50)-submit lab results
- Prostate exam (≥ age 40)

Additional tests/exams for Females:

- Mammogram (baseline radiologic mammogram report between the ages of 35-40- **required** Radiologic mammogram report results must be included with every PE (≥age 50)-**required**
- Pap-results (cervical cytology report) **and** report of pelvic physical findings **must** be within one year of the date of every 5 year physical- **required**

43. **Dental Defects and Disease**-
    Dentists **complete form PHS 6355**;
    Medical providers- **Acceptable or Not acceptable**-check the correct response;
    Class-leave blank
35. **FEET**-circle category

Page 2 of Form DD-2808 **Name and SERNO at top of page- must be completed**

Laboratory Findings section

*Dated and printed lab report findings **MUST** be submitted*

45. **Urinalysis**-Complete urinalysis (with microscopic if indicated)
46. **Urine HCG**-run test if indicated
47. **Hemoglobin/Hematocrit results along with CBC** report (with differential if WBC is abnormal) - ***required***
48. **Blood Type**-complete **only if** you do not know your blood type
49. **HIV**-optional
50. **Drugs**-optional
51. **Alcohol**-optional
52. **Other**-use as needed

Laboratory tests must be fasting (only water is allowed for 8 hours prior to test) **and must include:**

- Glucose
- Chem-20 (**electrolytes, metabolic panel, lipid panel)**-if lipids are elevated, you must submit evaluation report from your medical provider addressing all coronary artery disease risk factors and treatment recommendations- **required**
- Blood type-**if** you do not know your blood type
- Hgb A1C **for diabetics or as clinically indicated**

53. **Height**-without shoes- **required**
54. **Weight-required**
55. **Min wgt-Max wgt/Max BF%**-body fat test results as indicated for muscular individuals
56. **Temperature**-optional
57. **Pulse-*required***
58. **Blood Pressure-*required***
    a. Upon arrival in providers office;
    b. if indicated
    c. if indicated

Eye Exam by Optometry

59. **Red/Green**-optional
60. **Other Vision Test**-optional
61. **Distant Vision-*required***
62. **Refraction by Auto-refraction or Manifest**-optional
63. **Near Vision-*required***
64. **Heterophoria**-as clinically indicated
65. **Accommodation**-as clinically indicated
66. **Color Vision**-optional
67. **Depth Perception**-optional
68. **Field of Vision-*required for diabetics***
69. **Night Vision**-optional
70. **Intraocular Tension-*required for age* ≥*50***

Audiometer testing

71. a. **Numerical Values-*required***
    b. leave blank
72. a. **Reading Aloud-**optional
    b. **Valsalva**-optional
73. **Notes and Significant or Interval History**-use as indicated

Page 3 of Form DD-2808 **Name and SERNO at top of page-must be completed**

74a. & b. **Examinee/Applicant**-will be used by some Military Facilities.
Civilian providers leave these blank.

75. **I have been advised of my disqualifying condition**.
    a. **Signature of Examinee-** leave blank
    b. **Date**-leave blank

76. **Significant or Disqualifying Defects**-used in some MTFs, *civilian providers leave this blank.*
77. **Summary of Defects and Diagnoses**-list diagnoses.
78. **Recommendations-Further Specialist Examinations Indicated**-referrals to other health care providers are written in this space.
79. **MEPS Workload (for MEPS use only)-**leave blank
80. **Medical Inspection Date-**leave blank
81 a. and 82a. **Typed or Printed Name of Physician or Examiner** and 81b-82b. **Signature**-your providers *must* complete these items *and include the date of the exam.*
83. a. and b. **Typed or Printed Name of Dentist or Physician (Indicate which)** use as needed. **Signature**-your providers *must* complete these items *and include the date of the exam.*

84a. & b. Through 86. Leave blank.
87. **Number of Attached Sheets**-Optional

Physical Examinations must be submitted on the DD-2808.

Make sure your name and PHS SERNO are on every page submitted to the Medical Affairs' physical exam section.

Physical examinations must be complete according to these instructions when submitted to Medical Affairs.

PLEASE DO NOT MAIL OR FAX ANY PHYSICAL EXAMINATION DOCUMENTS.