REPORT OF MEDICAL HISTORY (This information is for official and medically confidential use only and will not be released to unauthorized persons.)						OMB No. 0704-0413 OMB approval expires September, 30 2021		
The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dd-information-collections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to collection of information if it does not display a currently valid OMB control number. PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.						all be		
ORĜANIZATIÓN. RÉTURN CŎMPLETED FORM AS INDICATED ON PAGE 2. PRIVACY ACT STATEMENT AUTHORITY: 10 U.S.C. 136, Under Secretary Of Defense For Personnel And Readiness; DoD Directive 1145.2, United States Military Entrance Processing Command; DoD Instruction 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services; and E.O. 9397 (SSN), as amended. PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted on the prescreening form (DD 2807-2). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted. 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/570661/ a0601-270-usmepcom-dod/ 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. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.						n I's		
				ial sta	tement. Federal law provides	s severe penalties (up to 5 yea	ars confinement or	a
 \$10,000 fine or both), to anyone making a false statement. 1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) 				2.a. SOCIAL SECURITY NO.	b. DoD ID NO. (If applicable)	3. TODAY'S DATE (YYYYMMDD)		
4.a. HOME ADDRESS	(Street, Apa	artment No., City, State	e, and ZIP Code	e)	5. EXAMINING LOCATION AN	ID ADDRESS (Include ZIP Code,)	
b. HOME TELEPHO c. EMAIL ADDRESS		Area Code)			-			
X ALL APPLICABL	F BOXES					7.a. POSITION (Title, Grade, Cor	mponent)	
6.a. SERVICE		b. COMPONENT	c. PURPOSE	OF EX				
Army Navy	Coast Guard	Regular Reserve	Retention Separation	n	Other (Specify)	b. USUAL OCCUPATION		
Marine Corps		National Guard	Medical E	Board				
Air Force			nt					
8. CURRENT MEDICATIONS (Prescription and Over-the-counter) 9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)								
Mark aaab itam "V	ES" or "N)" Even item mo	wad "VES" m	und h	o fully explained in Item 20	on Pogo 2		
					e fully explained in Item 29	on Page 2.	VEO	10
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DD FORM 2807-1 OCT 2018

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)			SOCIAL SECURITY NUMBER DoD ID NUMBER (If applicable)					
Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.								
HAVE YOU E	EVER HAD OR DO YOU NOW HAVE:	YES	NO		YES	NO		
15.a. Dizziness	s or fainting spells	0	\bigcirc	19. Have you been refused employment or been unable to hold a job				
b. Frequent	t or severe headache	0	0	or stay in school because of:				
c. A head in	njury, memory loss or amnesia	0	0	a. Sensitivity to chemicals, dust, sunlight, etc.	0	0		
d. Paralysis	3	0	0	b. Inability to perform certain motions	0	0		
e. Seizures	, convulsions, epilepsy or fits	0	0	c. Inability to stand, sit, kneel, lie down, etc.	\bigcirc	0		
f. Car, train	n, sea, or air sickness	0	0	d. Other medical reasons (If yes, give reasons.)	0	0		
g. A period	of unconsciousness or concussion	0	0	20. Have you ever been treated in an Emergency Room?	0	0		
h. Meningiti	is, encephalitis, or other neurological problems	0	0	(If yes, for what?)	\cup	\bigcirc		
16.a. Rheumat	tic fever	0	0	21. Have you ever been a patient in any type of hospital? (If yes,				
b. Prolonge	d bleeding (as after an injury or tooth extraction, etc.)	0	0	specify when, where, why, and name of doctor and complete		Ο		
c. Pain or p	ressure in the chest	0	\bigcirc	address of hospital.)				
d. Palpitatio	on, pounding heart or abnormal heartbeat	0	0	22. Have you ever had, or have you been advised to have any				
e. Heart tro	uble or murmur	0	\bigcirc	operations or surgery? (If yes, describe and give age at which		0		
f. High or lo	ow blood pressure	0	0	occurred.)				
17.a. Nervous	trouble of any sort (anxiety or panic attacks)	0	0	23. Have you ever had any illness or injury other than those	0	0		
b. Habitual	stammering or stuttering	0	0	already noted? (If yes, specify when, where, and give details.)	U	U		
c. Loss of n	nemory or amnesia, or neurological symptoms	0	\bigcirc	24. Have you consulted or been treated by clinics, physicians,				
d. Frequent	t trouble sleeping	0	0	healers, or other practitioners within the past 5 years for other than minor illnesses? (<i>If yes, give complete address</i> of doctor, hospital, clinic, and details.)		0		
e. Received	d counseling of any type	0	\bigcirc					
f. Depressio	on or excessive worry	0	0					
g. Been eva	aluated or treated for a mental condition	0	0	25. Have you ever been rejected for military service for any reason? (<i>If yes, give date and reason for rejection.</i>)	0	0		
h. Attempte	ed suicide	0	0	reason: (in yes, give date and reason for rejection.)				
i. Used ille	gal drugs or abused prescription drugs	0	0	26. Have you ever been discharged from military service for any				
18. FEMALES	ONLY. Have you ever had or do you now have:			reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or	0	0		
a. Treatme	ent for a gynecological (female) disorder	0	0	unsuitability.)				
b. A chang	e of menstrual pattern	0	0	27. Have you ever received, is there pending, or have you ever				
c. Any abn	ormal PAP smears	0	0	applied for pension or compensation for any disability	0	0		
d. First day	of last menstrual period (YYYYMMDD)			or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.)				
e. Date of I	last PAP smear (YYYYMMDD)			28. Have you ever been denied life insurance?	0	0		
29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical								
status.)								

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER (If applicable)
30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINE questions 10 - 29. Physician/practitioner may develop by interview a significant findings here.)	NT DATA (Physician/practitioner shall comr any additional medical history deemed impo	nent on all positive answers in rtant, and record any
a. COMMENTS		
b. TYPED OR PRINTED NAME OF EXAMINER (Last, First, Middle Initial) c	SIGNATURE	d. DATE SIGNED
		(YYYYMMDD)