# REPORT OF MEDICAL ASSESSMENT

**REPORT CONTROL SYMBOL**
DD-HA(AR)1939

**PRIVACY ACT STATEMENT**

**AUTHORITY:** PL 103-160, EO 9397.
**PRINCIPAL PURPOSE:** To be used by the Medical Services to provide a comprehensive medical assessment for active and reserve component service members separating or retiring from active duty.
**ROUTINE USES:** A copy of this form will be released to the Department of Veterans Affairs.
**DISCLOSURE:** Voluntary; however, failure to disclose the requested personal information may result in delay in processing any disability claim.

**SECTION I - TO BE COMPLETED BY SERVICE MEMBER. Any service member who requests a physical examination may have one.**

| 1. NAME *(Last, First, Middle)* | 2. SOCIAL SECURITY NUMBER | 3. RANK |
|---|---|---|
| | | |

| 4. COMPONENT | 5. UNIT OF ASSIGNMENT |
|---|---|
| | |

| 6a. HOME STREET ADDRESS *(Or RFD, including apartment number)* | b. CITY | c. STATE | d. ZIP CODE | 7. HOME TELEPHONE NUMBER *(Include area code)* |
|---|---|---|---|---|
| | | | | |

| 8. DATE OF LAST PHYSICAL EXAMINATION BY THE MILITARY *(YYMMDD)* | 9. DATE ENTERED ON CURRENT ACTIVE DUTY *(YYMMDD)* |
|---|---|
| | |

**10. COMPARED TO MY LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, MY OVERALL HEALTH IS** *(X one. If "Worse," explain.)*

- [ ] THE SAME
- [ ] BETTER
- [ ] WORSE

**11. SINCE YOUR LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, HAVE YOU HAD ANY ILLNESSES OR INJURIES THAT CAUSED YOU TO MISS DUTY FOR LONGER THAN 3 DAYS?** *(X one. If "Yes," explain.)*

- [ ] NO
- [ ] YES

**12. SINCE YOUR LAST MEDICAL ASSESSMENT/PHYSICAL EXAMINATION, HAVE YOU BEEN SEEN BY OR BEEN TREATED BY A HEALTH CARE PROVIDER, ADMITTED TO A HOSPITAL, OR HAD SURGERY?** *(X one. If "Yes," explain.)*

- [ ] NO
- [ ] YES

**13. HAVE YOU SUFFERED FROM ANY INJURY OR ILLNESS WHILE ON ACTIVE DUTY FOR WHICH YOU DID NOT SEEK MEDICAL CARE?** *(X one. If "Yes," explain.)*

- [ ] NO
- [ ] YES

**14. ARE YOU NOW TAKING ANY MEDICATIONS?** *(X one. If "Yes," list medications.)*

- [ ] NO
- [ ] YES

**15. DO YOU HAVE ANY CONDITIONS WHICH CURRENTLY LIMIT YOUR ABILITY TO WORK IN YOUR PRIMARY MILITARY SPECIALTY OR REQUIRE GEOGRAPHIC OR ASSIGNMENT LIMITATIONS?** *(X one. If "Yes," explain.)*

- [ ] NO
- [ ] YES

**16. DO YOU HAVE ANY DENTAL PROBLEMS?** *(X one. If "Yes," explain.)*

- [ ] NO
- [ ] YES

**17. DO YOU HAVE ANY OTHER QUESTIONS OR CONCERN ABOUT YOUR HEALTH?** *(X one. If "Yes," explain.)*

- [ ] NO
- [ ] YES

**18. AT THE PRESENT TIME, DO YOU INTEND TO SEEK DEPARTMENT OF VETERANS AFFAIRS (VA) DISABILITY?** *(X one. If "Yes," list conditions for which you will ask for VA Disability.)*

- [ ] NO
- [ ] YES
- [ ] UNCERTAIN

**19. CERTIFICATION. I certify that the information provided above is true and complete to the best of my knowledge.**

| a. SIGNATURE OF SERVICE MEMBER | b. DATE SIGNED |
|---|---|
| | |