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OMB No. 0704-0413

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making at late statements: 1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX) 2.a SOCIAL SECURITY NO. b. DoD ID NO. (If applicable) 3. TODAY'S DATE (YYYMMDD) 4.a. HOME ADDRESS (Stress, Apartment No., City, State, and ZIP Code) 5. EXAMINING LOCATION AND ADDRESS (Include Zip Code) 5. EXAMINING LOCATION AND ADDRESS (Include Zip Code) b. HOME TELEPHONE (Include Area Code) 5. EXAMINING LOCATION AND ADDRESS (Include Zip Code) 5. EXAMINING LOCATION AND ADDRESS (Include Zip Code) c. EMAIL ADDRESS 5. COMPONENT c. PURPOSE OF EXAMINATION Arr Force Beserve Response Marine Corps b. DOW ID Over the-Counter) b. USUAL OCCUPATION 8. CURRENT MEDICATIONS (Prescription and Over the-Counter) 9. ALLERGES (Including insect bites/strings, foods, medicine, or other substance) 0. Lived with insense with half tableculasis 0 1. (Continued) 9. ALLERGES (Including insect bites/strings, foods, medicine, or other substance) 1. Ave Force 1. (Continued) 9. ALLERGES (Including insect bites/strings, foods, medicine, or other substance) 0. Lived with insense with half tableculasis 0 1. (Continued) 1. (Continued) 1. (Continued) 0. Lived with insense with instation or marked "YES" must be fully explands or the other substance) 0 1. (Continued) 0 1. (Continued) 0.	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 from (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 t he recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a								
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DD FORM 2807-1, OCT 2018 PREVIOUS EDITION IS OBSOLETE.

CUI (when filled in)

Controlled by: OUSD(P&R) CUI Category: PRVCY, HLTH LDC: FEDCON POC: osd.pentagon.ousd-p-r.mbx.forms@mail.mil

CUI (when filled in)

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER DoD ID NUMBER (If applica	DoD ID NUMBER (If applicable)		
Mark each item "YES" or "NO". Every item mark	ed "YES" i	nust be fully explained in Item 29 below		
HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES NO		YES	NO
15.a. Dizziness or fainting spells	0 0	19. Have you been refused employment, or been unable to hold a job or stay		
b. Frequent or severe headache	$\circ \circ$	in school because of:		~
c. A head injury, memory loss or amnesia	\circ	a. Sensitivity to chemicals, dust, sunlight, etc.	0	0
d. Paralysis	ÕÕ	b. Inability to perform certain motions		0
e. Seizures, convulsions,epilepsy, or fits	Õ Õ	c. Inability to stand, sit, kneel, lie down, etc.	0	0
f. Car, train,sea,or air sickness	ÕÕ	d. Other medical reasons (If yes, give reasons.)	0	0
g. A period of unconsciousness or concussion	ŎŎ		s, for what?)	0
h. Meningitis, encephalitis, or other neurological problems	ÕÕ	20. Have you ever been treated in an Emergency Room? (If yes, for what?)		\bigcirc
16.a. Rheumatic fever	0 0			
b. Prolonged bleeding (as after an injury or tooth extraction, etc.)	ŎŎ	21. Have you ever been a patient in any type of hospital? (If yes, specify	\cap	\bigcirc
c. Pain or pressure in the chest	ÕÕ	when, where, why, and name of doctor and complete address of hospital.	mplete address of hospital. \bigcirc	\bigcirc
d. Palpitation, pounding heart or abnormal heartbeat	ŎŎ			
e. Heart trouble or murmur	ÕÕ	22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.)	\bigcirc	\bigcirc
f. High or low blood pressure				
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 already noted?		\sim
b. Habitual stammering or stuttering	ÕÕ	(If yes, specify when, where, and give details.)	\bigcirc	\bigcirc
c. Loss of memory or amnesia, or neurological symptoms		24. Have you consulted or been treated by clinics, physicians, healers, or		
d. Frequent trouble sleeping		other practitioners within the past 5 years for other than minor illnesses?	\bigcirc	\bigcirc
e. Received counseling of any type		(If yes, give complete address of doctor, hospital, clinic, and details.)	\cup	\cup
f. Depression or excessive worry	ÕÕ			
g. Been evaluated or treated for a mental condition	ÕÕ	25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.)	\bigcirc	\bigcirc
h. Attempted suicide	ÕÕ			
i. Used illegal drugs or abused prescription drugs	ÕÕ	26. Have you ever been discharged from military service for any reason? (If	\sim	\sim
18. FEMALES ONLY. Have you ever had or do you now have:	<u> </u>	yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)	0	0
a. Treatment for a gynecological (female) disorder	Õ Õ			
b. A change of menstrual pattern		27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what		\bigcirc
c. Any abnormal PAP smears		kind, granted by whom, and what amount, when , why.)	0	\bigcirc
d. First day of last menstrual period (YYYYMMDD)			0	0
e. Date of last PAP smear (YYYYMMDD)		28. Have you ever been denied life insurance?	0	0
e. Date of last PAP smear (YYYYMMDD)	()			

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.)

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

CUI (when filled in)

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER (If applicable)				
30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)						
a. COMMENTS						
b. TYPED OR PRINTED NAME OF EXAMINER (Last, First, Middle Initial)	c. SIGNATURE	d. DATE SIGNED (YYYYMMDD)				
DD EODM 2007 1 OCT 2019		Page 2 of 2				