Medical Certificate - Adult

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Physician's assessment of applicant's medical condition

1. APPLICANT

Name *(Last, First MI)*	AAFMAA Number *(if known)*
	Social Security Number
Gender ☐ Male ☐ Female	Birth Date *(mm/dd/yyyy)* / /

2. EXAMINER

Name *(Last, First MI)*	Title
Mailing Address	Daytime Phone

3. CLINICAL EVALUATION

Height *(feet/inches)*	Weight *(pounds)*	Systolic Blood Pressure(s) /
Pulse	Body Build ☐ Slender ☐ Medium ☐ Heavy ☐ Obese	Diastolic Blood Pressure(s) /

Based upon statements of the applicant, medical records, observation and examination, has the proposed Insured ever had or been diagnosed, treated or experienced any of the following? Provide explanations for all "YES" answers on Addendum form.

	YES	NO
1. Shortness of breath, chest pain, palpitations, heart abnormality, anemia, blood or blood vessel disease or hypertension		
2. Tuberculosis, asthma, pleurisy, or any disorder of the lungs		
3. Convulsions, epilepsy, stroke, loss of consciousness, brain or nervous disorder, anxiety, depression or mental illness		
4. Diabetes, albumin, sugar, pus, or blood in urine; any disease/disorder of the kidneys, bladder or prostate		
5. Growth, tumor, malignancy or cancer, disease of the skin, bones or joints; arthritis or rheumatism		
6. Excessive alcohol or drug use, or advice to limit, cease or receive counseling for alcohol or drug use		
7. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS-related conditions		
8. In the last five years, peptic ulcer, jaundice, gall stones, chronic diarrhea or any digestive or intestinal disorder		
9. In the last five years, any illness or injury for which a physician or other practitioner was consulted; disease or physical deformity, or surgical procedure or hospitalization		
10. In the last five years, ANY prescribed medication		
11. In the last 12 months, ANY use of nicotine delivery products (cigarette, cigar, pipe, snuff, chewing tobacco, gum, etc.)		
12. In the next 12 months, scheduled or anticipate any surgical procedures		

4. LAB WORK. Attach the following results to this certificate.

Blood Chemistry	Glucose, BUN, Alk Phos, AST (SGOT), ALT (SGPT), GGT, Triglycerides, Cholesterol, HDL Chol, Chol/HDL Ratio, LDL, HIV
Urinalysis	Protein, Glucose
EKG	Required for ages 55+
Male Age 50+	PSA result. Active duty within five years, non-active duty within one year.

5. SIGNATURE

I certify that I conducted a thorough examination as recorded on this day, and I find no abnormality of mind or body not noted on this report.

Examiner Signature	Exam Date (mm/dd/yyyy) / /

Medical Certificate Addendum

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Provide details for any medical questions answered "YES" below.

SIGNATURE. All statements and answers are true to the best of my knowledge.

Insured Name *(Last, First MI)*		Insured Social Security Number
Examiner Name *(Last, First MI)*	Examiner Signature	Date Signed *(mm/dd/yyyy)* / /

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