Before sending this form to me; you can add a password on the Adobe PDF file itself, this "ECNRYPTS" the file for protection of your information and then text me the password. You can also email me the document without password if you like. You may also look up on YouTube or Google how to properly do this if you don't know how to add a password to a PDF file.

U.S. AIR FORCE

UNITED STATES AIR FORCE RECRUITING

U.S. AIR FORCE

PRE-QUALIFICATION WORKSHEET

FIRST NAME: _____ LAST NAME: _____ MIDDLE INITIAL: ___ Age: _____ Todays' Date:_____

Place of Birth (city, State):_____ US Citizen/ Naturalized? YES ☐ NO ☐

Date of Birth (dd/mm/yyyy):_____Address (include city and zip):_____

Phone: _____ E-mail: _____

PRIOR SERVICE: YES ☐ NO ☐ If yes: ACTIVE ☐ RESERVE ☐ GUARD ☐ BRANCH: _____

EDUCATION LEVEL

HS STUDENT ☐ GED ☐ HS GRAD ☐ HOME SCHOOL ☐ COLLEGE ☐

High School Name/State: _____ Year Graduated: _____

(If Applicable) College: _____ GPA: _____ Semester/Qtr. Hours/Credits: _____

Have you ever taken the ASVAB? YES ☐ NO ☐ If yes: ASVAB QT ____ M ____ A ____ G ____ E ____

MARITAL/ DEPENDENCY STATUS

Marital Status: Single ☐ Married (civ) ☐ Married (mil) ☐ Separated ☐ Divorced ☐ Widowed ☐

How many children? _____ Is Spouse pregnant? _____

DRUGS

Have you ever used, sold, possessed any illegal drugs to include, but not limited to Marijuana? YES ☐ NO ☐

If Yes: Total times used: _____ Last time used: _____

LEGAL/ MORAL

Have you ever been arrested, charged, held or detained by law enforcement, **regardless** if you were told it would dropped, dismissed, sealed or expunged: YES ☐ NO ☐ If yes, explain:_____

_____

Speeding/ Parking tickets? YES ☐ NO ☐ If yes, how many? _____ Fines paid off? YES ☐ NO ☐

CREDIT HISTORY (Check all that apply): ☐ 60 Days Late ☐ 9 0 Days Late ☐ 120 Days Late Unpaid Judgements

Collections ☐ Charge offs ☐ Repossessions ☐ Bankruptcy ☐

Have you talked to another branch of service? Yes ☐ NO ☐ If YES, which branch?_____

MEDICAL

*** Height (inches): _____ Weight (lbs.): _____**

*** Review the DD Form 2807-2 (Attached below document) by selecting "yes" or "no" to all the questions.**

OFFICE USE ONLY:

EST/PICAT Score_____

Notes/ Remarks: _____

_____

SECTION II - MEDICAL HISTORY. ✓ All "Yes" items must be fully explained in Section III (Pages 4 and 5).

CURRENTLY HAVE OR *ANY HISTORY* OF:	YES	NO
EYES		
1. Double vision		
2. Detached retina or surgery to repair a detached retina		
3. Cataracts or surgery for cataracts		
4. Eye surgery to improve vision (RK, PRK, LASIK, etc.)		
5. Night blindness		
6. Glaucoma		
7. Strabismus or "lazy eye" or any surgery to correct these		
8. Any other eye condition, injury or surgery		
VISION		
9. Worn/wear contact lenses or glasses (Bring your contact lens kit and solution so you can remove contacts during vision testing, or for best results remove 72 hours prior. Bring your eyeglasses no matter how old they are.)		
10. Loss of vision in either eye		
11. Color vision deficiency or color blindness		
EARS		
12. Perforated ear drum or tubes in ear drum(s)		
13. Ear surgery, to include mastoidectomy or repair of perforated ear drum		
14. Loss of balance or vertigo		
HEARING		
15. Hearing loss or wear a hearing aid		
NOSE, SINUSES, MOUTH, AND LARYNX		
16. Ear, nose, or throat trouble including tonsillectomy		
17. Chronic sinus infections or recurrent nose bleeds		
18. Absence of, or disturbance of sense of smell		
19. Any surgery of your face, mandible or jaw		
DENTAL		
20. Do you wear dental braces or plan to wear braces? (If so, your orthodontist must submit a letter stating that active orthodontic treatment will be completed prior to active duty date: release form/ sample format can be found in the Recruiter's Medical Guide.)		
21. Tooth or gum problems (other than cavities)		

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM		
22. Asthma		
23. Wheezing		
24. Shortness of breath		
25. Bronchitis		
26. Other breathing problems worsened by exercise, weather, pollens, etc.		
27. Used inhaler(s) or steroids for breathing problem(s)		
28. Chronic cough or frequent coughing at night		
29. Collapsed lung or other lung condition		
30. History of chest, chest wall, or breast surgery		
HEART		
31. Heart murmur, valve problem or mitral valve prolapse		
32. Palpitation, pounding heart or abnormal heartbeat		
33. Heart surgery		
34. Pain or pressure in the chest		
35. An abnormal electrocardiogram (EKG)		
36. Any other heart problems		
ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM		
37. Stomach, esophageal or intestinal ulcer		
38. Difficulty swallowing		
39. Frequent indigestion or heartburn		
40. Gall bladder trouble or gallstones		
41. Jaundice (except neonatal) or hepatitis (liver disease)		
42. Rupture/hernia		
43. Surgery to remove or repair a portion of the intestine or spleen (other than the appendix)		
44. Chronic or recurrent intestinal problem of the small or large bowel such as Irritable Bowel Syndrome, Crohn's disease, Ulcerative Colitis, or Celiac disease		
45. Rectal disease, hemorrhoids, or blood from the rectum		
46. Hemorrhoid surgery		
47. Bariatric surgery (weight loss surgery)		

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*

SECTION II - MEDICAL HISTORY *(Continued)*. ✓ **All "Yes" items must be fully explained in Section III.**

CURRENTLY HAVE OR ***ANY HISTORY*** OF:	YES	NO
FEMALES ONLY:		
48. A change of menstrual pattern (other than pregnancy)		
49. Pregnancy, abortion or miscarriage		
50. Any abnormal PAP smear(s)		
51. Date of last PAP smear *(YYYYMMDD)*		
52. Diagnosed with endometriosis or ovarian cysts		
53. Evaluation, treatment or surgery for any other gynecological (female) disorder		
54. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)		
55. First day of last menstrual period *(YYYYMMDD)*		
MALES ONLY:		
56. Missing a testicle, testicular implant, or undescended testicle		
57. Variocele, hydrocele, or any scrotal mass, swelling or pain		
58. Prostate problems		
59. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)		
URINARY SYSTEM		
60. Missing a kidney		
61. Kidney stone, infection or disease		
62. Kidney or urinary tract surgery of any kind		
63. Blood or protein in urine		
64. Painful or difficult urination		
65. Bedwetting or treatment for bedwetting (after childhood)		
66. Hernia		
SPINE AND SACROILIAC JOINTS		
67. Recurrent back pain or back problem		
68. Herniated disk		
69. Recurrent neck pain		
70. Back or neck surgery		
71. Abnormal curvature of your spine (any part)		
UPPER EXTREMITIES		
72. Painful shoulder, elbow, wrist, hand or fingers		
73. Dislocated shoulder, elbow, wrist, hand or fingers		
LOWER EXTREMITIES		
74. Foot trouble (e.g., pain, corns, bunions, warts, ingrown toenails, etc.)		
75. Knee trouble (e.g., locking, giving out, or ligament injury, etc.)		
76. Painful hip, knee, ankle, foot or toes		
77. Dislocated hip, knee, ankle, foot or toes		
MISCELLANEOUS CONDITIONS OF THE EXTREMITIES		
78. Bone, joint, or other orthopedic deformity		
79. Loss of finger or toe, or extra finger or toe		
80. Loss of the ability to fully flex (bend) or fully extend a finger, toe, or other joint		
81. Impaired use of arms, hands, legs, or feet (any reason)		
82. Arthritis, rheumatism, or bursitis		
83. Any swollen joint(s)		
84. Surgery on any joint/bone (including arthroscopy)		
85. Plate(s), screw(s), rod(s) or pin(s) in any bone		
86. Pain or swelling at the site of an old fracture		
87. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics		
88. Any other orthopedic, muscle, or sports injury problems		
VASCULAR		
89. High or low blood pressure		
90. Raynaud's phenomenon or disease		
91. Deep Vein Thrombosis (blood clot; leg or elsewhere)		
92. Pulmonary embolism (blood clot in lung)		

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
SKIN AND CELLULAR		
93. Acne or psoriasis		
94. Eczema		
95. Atopic dermatitis		
96. Large or painful scars		
97. Any other skin problems		
BLOOD AND BLOOD FORMING TISSUES		
98. Anemia		
99. Blood clots requiring blood thinner medicine		
100. Absence or removal of the spleen		
101. Prolonged bleeding (after an injury or tooth extraction)		
102. Any other blood or circulation problems		
SYSTEMIC		
103. Adverse reaction to medication (describe reaction in Section III)		
104. Adverse reaction to serum, insect stings, or tree nuts		
105. Allergy to common foods (milk, eggs, fish, meat, etc.)		
106. Allergy to wool, latex, or other material		
107. Tuberculosis or lived with someone who had tuberculosis		
108. Positive test for tuberculosis (PPD or blood test)		
109. Malaria		
110. Disorder(s) of your immune system (including HIV)		
111. Car, train, sea, or air sickness		
ENDOCRINE AND METABOLIC		
112. Thyroid trouble or goiter		
113. High or low blood sugar		
114. Diabetes or told that you should be tested for diabetes		
NEUROLOGIC		
115. Cerebrovascular incident (stroke)		
116. Frequent or severe headaches, including migraines		
117. Taking medication to prevent headaches		
118. Lost time from work or school due to frequent or severe headaches		
119. A skull fracture		
120. A head injury, memory loss, or amnesia		
121. A period of unconsciousness or concussion		
122. Loss of memory or amnesia, or neurological symptoms		
123. Paralysis		
124. Meningitis, encephalitis, or other neurological problems		
125. Seizures, convulsions, epilepsy or fits		
126. Dizziness or fainting spells		
127. Any other neurologic problems		
SLEEP DISORDERS		
128. Sleepwalking or narcolepsy		
129. Frequent trouble sleeping		
130. Sleep apnea or severe snoring		
LEARNING, PSYCHIATRIC, AND BEHAVIORAL		
131. Evaluated or treated for Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)		
132. Taken (or taking) medication, drugs, or any substance to improve attention, behavior, or physical performance		
133. Diagnosed with a learning disorder, to include dyslexia		
134. Received counseling of any type		
135. Seen a psychiatrist, psychologist, social worker, counselor or other professional for any reason (inpatient or out-patient) including counseling or treatment for school, adjustment, family, marriage, divorce, depression, anxiety, or treatment of alcohol, drug or substance abuse (Applicant or recruiter will request sealed medical supporting documents from health care providers marked "CONFIDENTIAL: MEPS MEDICAL DEPARTMENT" and submit directly to MEPS medical personnel.)		

LAST NAME - FIRST NAME - MIDDLE INITIAL (SUFFIX)	SOCIAL SECURITY NUMBER *(Last 4)*

SECTION II - MEDICAL HISTORY *(Continued)*. All "Yes" items must be fully explained in Section III.

CURRENTLY HAVE OR ***ANY HISTORY*** OF:	YES	NO
LEARNING, PSYCHIATRIC, AND BEHAVIORAL *(Continued)*		
136. Been expelled or suspended from school		
137. Been kicked out or removed from your home		
138. Been arrested or other encounters with law enforcement		
139. Been evaluated or treated, either with medication or counseling, for a mental condition, depression or excessive worry		
140. Nervous trouble of any sort (anxiety or panic attacks)		
141. Anorexia, bulimia, or other eating disorder		
142. Habitual stammering or stuttering		
143. Have you ever purposely cut or harmed yourself		
144. Have you ever attempted or considered suicide		
145. Used illegal drugs or abused prescription drugs		
146. Have you been evaluated, treated, or hospitalized for substance abuse, addiction or dependence (including illegal drugs, prescription medications or other substances)		
147. Have you been evaluated, treated, or hospitalized for alcohol abuse, dependence, or addiction		
148. Post-traumatic Stress Disorder or excessive stress requiring counseling and/or medication following a traumatic experience		
149. Any other learning, psychiatric, or behavioral problems		
TUMORS AND MALIGNANCIES		
150. Tumor, growth, cyst, or cancer of any type		
MISCELLANEOUS		
151. Cold injury, frostbite or cold intolerance		
152. Heat injury, heat stroke or heat intolerance		
SUPPLEMENTAL QUESTIONS		
153. Are you taking any medications, to include over the counter medications (OTCs), vitamin, herbal, or nutritional supplements (If "yes", list all in Section III.)		

CURRENTLY HAVE OR ANY HISTORY OF:	YES	NO
SUPPLEMENTAL QUESTIONS *(Continued)*		
154. Any recent unexplained gain or loss of weight		
155. Artificial or replacement body part (eye, bone, palate, hip, knee, joint, leg, arm, etc.)		
156. Have you ever had any illness or injury other than those already noted? (If "yes", specify when, where and give details in Section III.)		
157. Have you ever been treated in an Emergency Room? (If "yes", explain in Section III.)		
158. Have you ever been a patient in any type of hospital (including being kept overnight)? (If "yes", specify when, where, why, and name of doctor and complete address of hospital in Section III.)		
159. Have you ever had, or have you been advised to have any operations or surgery? (If "yes", describe and give age at which occurred in Section III.)		
160. Have you ever been rejected for military Service for any reason? (If "yes", give date and reason in Section III.)		
161. Have you ever been discharged from the military Service for any reason? (If "yes", give date, reason, and type of discharge, whether honorable, other than honorable, for unfitness or unsuitability in Section III.)		
162. Have you ever been refused employment or been unable to hold a job or stay in school because of any of the following: (If "yes", answer a - d below and give reasons in Section III.)		
a. Sensitivity to chemicals, dust, sunlight, etc.		
b. Inability to perform certain motions		
c. Inability to stand, sit, kneel, lie down, etc.		
d. Other medical reasons		
163. Applied for and/or received disability evaluation and/or compensation for an injury or other medical conditions (If "yes", provide details in Section III.)		
164. Have you ever been denied life insurance? (If "yes", provide reason(s) in Section III.)		

SECTION III - APPLICANT COMMENTS. Explain all "Yes" answers to questions 1 - 164 above. To the best of your knowlege.

-Begin with the Item Number.
-Provide date(s) of problem(s)/condition(s); HOW OLD WERE YOU AT THE TIME.
-Describe answer(s) fully: provide names of Health Care Providers (HCPs), Clinic(s) and/or Hospital(s) along with the City and State;
-explain what was done (e.g., evaluation and/or treatment); and describe your current medical status.

******EXAMPLE: #9 01JAN1995 – Current *I have worn glasses since the age of 5 and still currently wear eye glasses. I am treated at Clinic of Eye Care by Dr. Johnson. Address and phone number. No further complications.**

List all law violations to include traffic tickets regardless of the outcome.				
Drivers License #:		**Expiration date:**		**City Issued in:**
Date	**Violation**	**City & State**	**Disposition**	**Amount of Fines**

In the block below, write a few sentences explaining your personal and career interests that you are looking for the Air Force to provide for you.

Once this form is completed, please e-mail it back to me so I can determine your qualifications.

Before sending this form to me, you can add a password on the Adobe PDF file itself, this "ECNRYPTS" the file for protection of your information and then text me the password. You can also email me the document without password if you like. You may also look up on YouTube or Google how to properly do this if you don't know how to add a password to a PDF file.