s. History of congenital anomalies of the heart and great vessels other than the following conditions. Excepted conditions require an otherwise normal current echocardiogram within the last 12 months.

(1) Dextrocardia with situs inversus without any other anomalies.

(2) Ligated or occluded patent ductus arteriosus.

(3) Corrected atrial septal defect without residua.

(4) Patent foramen ovale.

(5) Corrected ventricular septal defect without residua.

t. History of recurrent syncope or presyncope, including black out, fainting, loss or alteration of level of consciousness (excludes single episode of vasovagal reaction with identified trigger such as venipuncture) unless it has not recurred during the preceding 2 years while off all medication for treatment of this condition.

u. Unexplained ongoing or recurring cardiopulmonary symptoms (to include but not limited to syncope, presyncope, chest pain, palpitations, and dyspnea on exertion).

v. History of Postural Orthostatic Tachycardia Syndrome.

w. History of rheumatic fever if associated with rheumatic heart disease or indication for ongoing prophylactic medication.

5.12. ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM.

a. Esophageal Disease.

(1) History of Gastro-Esophageal Reflux Disease, with complications, including, but not limited to:

(a) Stricture.

(b) Dysphagia.

(c) Recurrent symptoms or esophagitis despite maintenance medication.

(d) Barrett's esophagus.

(e) Extraesophageal complications such as: reactive airway disease; recurrent sinusitis or dental complications; unresponsive to acid suppression.

(2) History of surgical correction (e.g., fundoplication) for Gastro-Esophageal Reflux Disease within 6 months or with complications.

(3) History of dysmotility disorders to include but not limited to diffuse esophageal spasm, nutcracker esophagus, and achalasia.

(4) History of eosinophilic esophagitis.

(5) History of other esophageal strictures (e.g., from ingesting lye).

(6) History of esophageal disease not specified above; including but not limited to neoplasia, ulceration, varices, or fistula.

b. Stomach and Duodenum.

(1) Current dyspepsia, gastritis, or duodenitis despite medication (over the counter or prescription).

(2) Current gastric or duodenal ulcers, including but not limited to peptic ulcers and gastrojejunal ulcers:

(a) History of a treated ulcer within the last 3 months.

(b) Recurrent or complicated by bleeding, obstruction, or perforation within the previous 5 years.

(3) History of surgery for peptic ulceration or perforated ulcer.

(4) History of gastroparesis of greater than 6 week's duration, confirmed by scintigraphy or equivalent test.

(5) History of bariatric surgery of any type (e.g., lap-band or gastric bypass surgery for weight loss).

(6) History of gastric varices.

c. Small and Large Intestine.

(1) History of inflammatory bowel disease, including but not limited to Crohn's disease, ulcerative colitis, ulcerative proctitis, or indeterminate colitis.

(2) Current infectious colitis.

(3) History of intestinal malabsorption syndromes, including but not limited to celiac sprue, pancreatic insufficiency, post-surgical and idiopathic.

(4) Dietary intolerances that may interfere with military duty or consuming military rations. Lactase deficiency does not meet the standard only if of sufficient severity to require frequent intervention, or to interfere with military duties.

(5) History of gastrointestinal functional or motility disorders including but not limited to volvulus within the past 24 months, or any history of pseudo-obstruction or megacolon.

(6) Current chronic constipation, requiring prescription medication or medical interventions (e.g., pelvic floor physical therapy, biofeedback therapy).

(7) History of diarrhea of greater than 6 weeks duration, regardless of cause, persisting or symptomatic in the past 2 years.

(8) History of gastrointestinal bleeding, including positive occult blood, if the cause requires treatment and has not been corrected.

(9) History of irritable bowel syndrome of sufficient severity to require frequent intervention or prescription medication or that may reasonably be expected to interfere with military duty.

(10) History of symptomatic diverticular disease of the intestine.

(11) Personal or family history of familial adenomatous polyposis syndrome or hereditary non-polyposis colon cancer (Lynch syndrome).

d. Hepatic-Biliary Tract.

(1) History of chronic Hepatitis B unless successfully treated and the cure is documented. A documented cure for Hepatitis B is viral clearance manifested by Hepatitis B surface antigen negative/Hepatitis B surface antibody positive/Hepatitis B core antibody positive.

(2) History of chronic Hepatitis C, unless successfully treated and with documentation of a cure 12 weeks after completion of a full course of therapy.

(3) Other acute hepatitis in the preceding 6 months, or persistence of symptoms or abnormal serum aminotransferases after 6 months, or objective evidence of impairment of liver function.

(4) History of cirrhosis, hepatic abscess, or complications of chronic liver disease.

(5) History of symptomatic gallstones or gallbladder disease unless successfully treated.

(6) History of sphincter of Oddi dysfunction.

(7) History of choledochal cyst.

(8) History of primary biliary cirrhosis or primary sclerosing cholangitis.

(9) History of metabolic liver disease, excluding Gilbert's syndrome. This includes but is not limited to hemochromatosis, Wilson's disease, or alpha-1 anti-trypsin deficiency.

(10) History of alcoholic or non-alcoholic fatty liver disease if there is evidence of chronic liver disease, manifested as impairment of liver function or hepatic fibrosis.

(11) History of traumatic injury to the liver within the preceding 6 months.

e. Pancreas. History of:

(1) Pancreatic insufficiency.

(2) Acute pancreatitis, unless due to cholelithiasis successfully treated by cholecystectomy.

(3) Chronic pancreatitis.

(4) Pancreatic cyst or pseudocyst.

(5) Pancreatic surgery.

f. Anorectal.

(1) Current anal fissure or anal fistula.

(2) History of rectal prolapse or stricture within the last 2 years.

(3) History of fecal incontinence after the 13th birthday.

(4) Current hemorrhoid (internal or external), if symptomatic or requiring medical intervention within the last 60 days.

g. Abdominal Wall.

(1) Current abdominal wall hernia other than small (less than 2 centimeters (cm) in size), asymptomatic inguinal or umbilical hernias.

(2) History of open or laparoscopic abdominal surgery during the preceding 3 months.

(3) The presence of any ostomy (gastrointestinal or urinary).

5.13. FEMALE GENITAL SYSTEM.

a. Abnormal uterine bleeding (period greater than 7 days, or more frequent than 21 days or greater than 35 days, or soaking more than one pad per hour for several hours) within the last 12 months.

b. Primary amenorrhea.

c. Current unexplained secondary amenorrhea.

d. Dysmenorrhea resulting in recurrent absences or activity modification within the last 6 months.

e. History of symptomatic endometriosis.

f. History of major abnormalities or defects of the genitalia, such as hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis.

g. Current ovarian cyst(s) greater than 5 cm.

h. Polycystic ovarian syndrome unless no evidence of metabolic complications as specified by National Heart, Lung, and Blood Institute and American Heart Association Guidelines.

i. Pelvic inflammatory disease within the preceding 6 months.

j. History of chronic pelvic pain (6 months or longer) within the last 24 months.

k. Pregnancy through 6 months after the completion of the pregnancy.

l. Uterine enlargement due to any cause.

m. History of genital infection or ulceration, including but not limited to herpes genitalis or condyloma acuminatum, if any of the following apply:

(1) Current lesions are present.

(2) Use of chronic suppressive therapy is needed.

(3) There have been three or more outbreaks per year.

(4) Any outbreak in the past 12 months that interfered with normal life activities.

(5) After the initial outbreak, treatment that included hospitalization or intravenous therapy.

n. Abnormal gynecologic cytology within the preceding 3 years, including but not limited to unspecified abnormalities of the Papanicolaou smear of the cervix, excluding atypical squamous cells of undetermined significance without human papillomavirus and confirmed low-grade squamous intraepithelial lesion. For the purposes of this issuance, confirmation is by colposcopy or repeat cytology.

o. History of abnormal cervical, vaginal, or vulvar cytology or pathology to include atypical squamous cells that cannot exclude high grade squamous intraepithelial lesions, low-grade squamous intraepithelial lesions, high-grade squamous intraepithelial lesions, cervical intraepithelial neoplasia grades 2 or 3, vaginal intraepithelial neoplasia grades 2 or 3, vulvar intraepithelial neoplasia grades 2 or 3 without demonstrated resolution in accordance with American Society for Colposcopy and Cervical Pathology guidelines.

p. History of abnormal endometrial pathology within the last 3 years (e.g., simple or complex hyperplasia with or without atypia) without demonstrated resolution in accordance with American Society for Colposcopy and Cervical Pathology guidelines.

5.14. MALE GENITAL SYSTEM.

a. Absence of both testicles, current undescended testicle, or congenital absence of one testicle not verified by surgical exploration.

b. History of epispadias or hypospadias when accompanied by history of urinary tract infection, urethral stricture, urinary incontinence, symptomatic chordee, or voiding dysfunction or surgical intervention for these issues within the past 24 months.

c. Current enlargement or mass of testicle, epididymis, or spermatic cord, in addition to those described elsewhere in Paragraph 5.14.

d. Current hydrocele or spermatocele associated with pain or which precludes a complete exam of the scrotal contents.

e. Current varicocele, unless it is:

(1) On the left side only.

(2) Asymptomatic and smaller than the testes.

(3) Reducible.

(4) Without associated testicular atrophy.

f. Current or history of recurrent orchitis or epididymitis.

g. History of penis amputation.

h. Current penile curvature if associated with pain.

i. History of genital infection or ulceration, including but not limited to herpes genitalis or condyloma acuminatum, if:

(1) Current lesions are present;

(2) Use of chronic suppressive therapy is needed;

(3) There are three or more outbreaks per year;

(4) Any outbreak in the past 12 months interfered with normal activities; or

(5) After the initial outbreak, treatment included hospitalization or intravenous therapy.

j. History of urethral condyloma acuminatum.

k. History of acute prostatitis within the last 24 months, history of chronic prostatitis, or history of chronic pelvic pain syndrome.

l. History of chronic or recurrent scrotal pain or unspecified symptoms associated with male genital organs.

m. History of major abnormalities or defects of the genitalia such as hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis.

5.15. URINARY SYSTEM.

a. History of interstitial cystitis or painful bladder syndrome.

b. Lower urinary tract infection (cystitis):

(1) For males, any cystitis not related to an indwelling catheter during a hospitalization.

(2) For females, current cystitis or recurrent cystitis of greater than two episodes per year, or requiring daily suppressive antibiotics, or non-responsive to antibiotics for 10 days.

c. Current urethritis.

d. History or treatment of the following voiding symptoms within the previous 12 months in the absence of a urinary tract infection:

(1) Urinary frequency or urgency more than every 2 hours on a daily basis.

(2) Nocturia more than two episodes during sleep period.

(3) Enuresis.

(4) Incontinence of urine, such as urge or stress.

(5) Urinary retention.

(6) Dysuria.

e. History of neurogenic bladder or other functional disorder of the bladder that requires urinary catheterization with intermittent or indwelling catheter for any period greater than 2 weeks.

f. History of bladder augmentation, urinary diversion, or urinary tract reconstruction.

g. History of abnormal urinary findings in the absence of urinary tract infection:

(1) Gross hematuria.

(2) Persistent microscopic hematuria (3 or more red blood cells per high-powered field on properly collected urinalyses, unless urology evaluation determines benign essential hematuria).

(3) Pyuria (6 or more white blood cells per high-powered field in 2 of 3 properly collected urinalyses).

h. Current or recurrent urethral or ureteral stricture or fistula involving the urinary tract.

i. Absence of one kidney, congenital or acquired.

j. Asymmetry in size or function of kidneys.

k. History of renal transplant.

l. Chronic or recurrent pyelonephritis or any other unspecified infections of the kidney.

m. History of polycystic kidney.

n. History of horseshoe kidney.

o. Hydronephrosis on most recent imaging not related to pregnancy.

p. History of acute nephritis or chronic kidney disease of any type as evidenced by 3 months or longer of:

(1) Estimated glomerular filtration rate of less than 60cc per minute per 1.73 square meter of body surface area or abnormal renal imaging;

(2) Casturia; or

(3) Abnormal renal biopsy.

q. History of acute kidney injury requiring dialysis.

r. History of proteinuria with a protein-to-creatinine ratio greater than 0.2 in a random urine sample, more than 48 hours after strenuous activity, excluding benign orthostatic proteinuria.

s. Urolithiasis if any of the following apply:

(1) Current stone of 3 mm or greater.

(2) Current multiple stones of any size.

(3) History of symptomatic urolithiasis within the preceding 12 months.

(4) History of nephrocalcinosis, bilateral renal calculi, or recurrent urolithiasis at any time.

(5) History of urolithiasis requiring a procedure.

5.16. SPINE AND SACROILIAC JOINT CONDITIONS.

a. Ankylosing spondylitis or other inflammatory spondylopathies.

b. History of any condition, in the last 2 years, or any recurrence, including but not limited to the spine or sacroiliac joints, with or without objective signs, if:

(1) It prevents the individual from successfully following a physically active avocation in civilian life, or is associated with local or radicular pain, muscular spasms, postural deformities, or limitation in motion;

(2) It requires external support;

(3) It requires limitation of physical activity or frequent treatment; or

(4) It requires the applicant to use medication for more than 6 weeks.

(5) It causes one or more episodes of back pain lasting greater than 6 weeks requiring treatment other than self-care.

c. Current deviation or curvature of the spine from normal alignment, structure, or function if:

(1) It prevents the individual from following a physically active avocation in civilian life;

(2) It can reasonably be expected to interfere with the proper wearing of military uniform or equipment;

(3) It is symptomatic; or

(4) There is lumbar or thoracic scoliosis greater than 30 degrees, or thoracic kyphosis greater than 50 degrees when measured by the Cobb Method.

d. History of congenital fusion involving more than 2 vertebral bodies or any surgical fusion of spinal vertebrae.

e. Current dislocation of the vertebra.

f. Vertebral fractures including but not limited to:

(1) Any cervical spine fracture.

(2) History of fracture of lumbar or thoracic vertebral body that exceeds 25 percent of the height of a single vertebra or that has occurred within the last 12 months or is symptomatic.

(3) A history of fractures of the transverse or spinous process if currently symptomatic.

g. History of juvenile epiphysitis with any degree of residual change indicated by X-ray or Scheuermann's kyphosis.

h. History of uncorrected herniated nucleus pulposus associated with any treatment, symptoms, or activity limitations.

i. History of surgery to correct herniated nucleus pulposus other than a single-level lumbar or thoracic diskectomy that is currently asymptomatic with full resumption of unrestricted activity for at least 12 months.

j. Spinal dysraphisms other than spina bifida occulta.

k. History of spondylolysis or spondylolisthesis, congenital or acquired.

5.17. UPPER EXTREMITY CONDITIONS.

a. Limitation of Motion. Current active joint ranges of motion less than:

(1) Shoulder.

(a) Forward elevation to 130 degrees.

(b) 130 degrees abduction.

(c) 60 degrees external and internal rotation at 90 degrees abduction.

(d) Cross body reaching 115 degrees adduction.

(2) Elbow.

(a) Flexion to 130 degrees.

(b) Extension to 30 degrees.

(3) Wrist. A total range of 60 degrees (extension plus flexion), or radial and ulnar deviation combined are 30 degrees.

(4) Hand.

(a) Pronation to 45 degrees.

(b) Supination to 45 degrees.

(5) Fingers and Thumb. Inability to clench fist, pick up a pin, grasp an object, or touch tips of at least three fingers with thumb.

b. Hand and Fingers.

(1) Absence of the distal phalanx of either thumb.

(2) Absence of any portion of the index finger.

(3) Absence of 2 or more distal and middle phalanges of the middle, ring, or small finger of either hand.

(4) Absence of 2 or more distal phalanges of any finger on either hand.

(5) Absence of hand or any portion thereof, except for specific absence of fingers as noted in Paragraphs 5.17.b.(1)-(4).

(6) Current polydactyly or syndactyly.

(7) Intrinsic paralysis or weakness of upper limbs, including but not limited to nerve paralysis, carpal tunnel, and cubital syndromes, lesion of ulnar, median, or radial nerve, sufficient to produce physical findings in the hand such as muscle atrophy and weakness.

c. Residual Weakness and Pain. Current disease, injury, or congenital condition with residual weakness, pain, sensory disturbance, or other symptoms that may reasonably be expected to prevent satisfactory performance of duty, including but not limited to chronic joint pain associated with the shoulder, the upper arm, the forearm, and the hand; or chronic joint pain as a late effect of fracture of the upper extremities, as a late effect of sprains without mention of injury, and as late effects of tendon injury.

5.18. LOWER EXTREMITY CONDITIONS.

a. General.

(1) Current deformities, disease, or chronic joint pain of pelvic region, thigh, lower leg, knee, ankle or foot that prevent the individual from following a physically active avocation in civilian life, or that may reasonably be expected to interfere with walking, running, weight bearing, or with satisfactorily completing training or military duty.

(2) Current discrepancy in leg-length that causes a limp.

b. Limitation of Motion. Current active joint ranges of motion less than:

(1) Hip.

(a) Flexion to 90 degrees.

(b) No demonstrable flexion contracture.

(c) Extension to 10 degrees (beyond 0 degrees).

(d) Abduction to 45 degrees.

(e) Rotation of 60 degrees (internal and external combined).

(2) Knee.

(a) Full extension to 0 degrees.

(b) Flexion to 110 degrees.

(3) Ankle.

(a) Dorsiflexion to 10 degrees.

(b) Planter flexion to 30 degrees.

(c) Subtalar eversion and inversion totaling 5 degrees.

c. Foot and Ankle.

(1) Current absence of a foot or any portion thereof, other than absence of a single lesser toe that is asymptomatic and does not impair function of the foot.

(2) Deformity of the toes that may reasonably be expected to prevent properly wearing military footwear or impair walking, marching, running, maintaining balance, or jumping.

(3) Symptomatic deformity of the toes (acquired or congenital), including but not limited to conditions such as hallux valgus, hallux varus, hallux rigidus, hammer toe(s), claw toe(s), or overriding toe(s).

(4) Clubfoot or pes cavus that may reasonably be expected to properly wearing military footwear or causes symptoms when walking, marching, running, or jumping.

(5) Rigid or symptomatic pes planus (acquired or congenital).

(6) Current ingrown toenails, if infected or symptomatic.

(7) Current or recurrent plantar fasciitis.

(8) Symptomatic neuroma.

d. Leg, Knee, Thigh, and Hip.

(1) Current loose or foreign body in the knee joint.

(2) History of uncorrected anterior or posterior cruciate ligament injury.

(3) History of surgical reconstruction of knee ligaments within the last 12 months, or which is symptomatic or unstable or shows signs of thigh or calf atrophy.

(4) Recurrent anterior cruciate ligament reconstruction.

(5) Current medial or lateral meniscal injury with symptoms or limitation of activity.

(6) Surgical meniscal repair, within the last 6 months or with residual symptoms or limitation of activity.

(7) Surgical partial meniscectomy within the last 3 months or with residual symptoms or limitation of activity.

(8) Meniscal transplant.

(9) Symptomatic medial and lateral collateral ligament instability.

(10) History of developmental dysplasia (congenital dislocation) of the hip, osteochondritis of the hip (Legg-Calve-Perthes Disease), or slipped capital femoral epiphysis of the hip.

(11) History of hip dislocation.

(12) Symptomatic osteochondritis of the tibial tuberosity (Osgood-Schlatter Disease) within the past 12 months.

(13) Stress fractures, either recurrent or a single episode occurring during the past 12 months.

5.19. MISCELLANEOUS CONDITIONS OF THE EXTREMITIES.

a. History of chondromalacia, including but not limited to chronic patello-femoral pain syndrome and retro-patellar pain syndrome, osteoarthritis, or traumatic arthritis.

b. Dislocation of patella if two or more episodes, or any occurring within the last 12 months.

c. History of any dislocation, subluxation, or instability of the hip, knee, ankle, subtalar joint, foot, shoulder, wrist, elbow except for "nursemaid's elbow" or dislocated finger.

d Acromioclavicular separation within the last 12 months or if symptomatic.

e. History of osteoarthritis or traumatic arthritis of isolated joints that has interfered with a physically active lifestyle, or that may reasonably be expected to prevent satisfactorily performing military duty.

f. Fractures, if:

(1) Current malunion or non-union of any fracture (except asymptomatic ulnar styloid process fracture).

(2) Current retained hardware (including plates, pins, rods, wires, or screws) used for fixation that is symptomatic or may reasonably be expected to interfere with properly wearing military equipment or uniforms. Retained hardware is not disqualifying if fractures are healed, ligaments are stable, and there is no pain.

g. Current orthopedic implants or devices to correct congenital or post-traumatic orthopedic abnormalities except for bone anchor and hardware as allowed in accordance with Paragraph 5.19.f.(2).

h. History of contusion of bone or joint if:

(1) The injury is of more than a minor nature with or without fracture, nerve injury, open wound, crush, or dislocation which occurred within the last 6 months;

(2) Recovery has not been sufficiently completed or rehabilitation has not been sufficiently resolved;

(3) The injury may reasonably be expected to interfere with or prevent performance of military duty; or

(4) The contusion requires frequent or prolonged treatment.

i. History of joint replacement or resurfacing of any site.

j. History of hip arthroscopy or femoral acetabular impingement.

k. History of neuromuscular paralysis, weakness, contracture, or atrophy not completely resolved and of sufficient degree to reasonably be expected to interfere with or prevent satisfactory performing military duty.

l. Current symptomatic osteochondroma or history of two or more osteocartilaginous exostoses.

m. History of atraumatic fractures or bone mineral density below the expected range for age with risk factors for low bone density.

n. Osteopenia, osteoporosis, or history of fragility fracture.

o. History of osteomyelitis within the past 12 months, or history of recurrent osteomyelitis.

p. History of osteochondral defect, formerly known as osteochondritis dissecans.

q. History of cartilage surgery, including but not limited to cartilage debridement or chondroplasty for Grade III or greater chondromalacia, microfracture, or cartilage transplant procedure.

r. History of any post-traumatic or exercise-induced compartment syndrome.

s. History of osteonecrosis of any bone.

t. History of recurrent tendon disorder, including but not limited to tendonitis, tendonopathy, tenosynovitis.

5.20. VASCULAR SYSTEM.

a. History of abnormalities of the arteries, including but not limited to aneurysms, arteriovenous malformations, atherosclerosis, or arteritis (e.g., Kawasaki's disease).

b. Current or medically-managed hypertension. Hypertension is defined as systolic pressure greater than 140 millimeters of mercury (mmHg) or diastolic pressure greater than 90 mmHg confirmed by manual blood pressure cuff averaged over two or more properly measured, seated, blood pressure readings on separate days within a 5-day period (isolated, single-day blood pressure elevation is not disqualifying unless confirmed on 2 separate days within a 5-day period).

c. History of peripheral vascular disease, including but not limited to diseases such as Raynaud's Disease and vasculitides.

d. History of venous diseases, including but not limited to recurrent thrombophlebitis, thrombophlebitis during the preceding year, or evidence of venous incompetence, such as edema, skin ulceration, or symptomatic varicose veins that would reasonably be expected to limit duty or properly wearing military uniform or equipment.

e. History of deep venous thrombosis.

f. History of operation or endovascular procedure on the arterial or venous systems, including but not limited to vena cava filter, angioplasty, venoplasty, thrombolysis, or stent placement.

g. History of Marfan's Syndrome, Loey-Dietz, or Ehlers Danlos IV.

5.21. SKIN AND SOFT TISSUE CONDITIONS.

a. Applicants under treatment with systemic retinoids, including, but not limited to isotretinoin (e.g. Accutane®), do not meet the standard until 4 weeks after completing therapy.

b. Severe nodulocystic acne, on or off antibiotics.

c. History of dissecting scalp cellulitis, acne inversa, or hidradenitis suppurativa.

d. History of atopic dermatitis or eczema after the 12th birthday. History of residual or recurrent lesions in characteristic areas (face, neck, antecubital or popliteal fossae, occasionally wrists and hands).

e. History of recurrent or chronic non-specific dermatitis within the past 2 years to include contact (irritant or allergic) or dyshidrotic dermatitis requiring more than treatment with topical corticosteroid.

f. Cysts, if:

(1) The current cyst (other than pilonidal cyst) is of such a size or location as to reasonably be expected to interfere with properly wearing military equipment.

(2) The current pilonidal cyst is associated with a tumor mass or discharging sinus, or is a surgically resected pilonidal cyst that is symptomatic, unhealed, or less than 6 months post-operative. A pilonidal cyst that has been simply incised and drained does not meet the military accession medical entrance standard.

g. History of bullous dermatoses, including but not limited to dermatitis herpetiformis, pemphigus, and epidermolysis bullosa.

h. Current or chronic lymphedema.

i. History of furunculosis or carbuncle if extensive, recurrent, or chronic.

j. History of severe hyperhidrosis of hands or feet unless controlled by topical medications.

k. History of congenital or acquired anomalies of the skin, such as nevi or vascular tumors that may interfere with military duties or cause constant irritation.

l. History of severe keloid formation.

m. History of pseudofolliculitis barbae or keloidalis nuchae, severe enough to prevent daily shaving or would reasonably be expected to interfere with wearing military equipment.

n. Current lichen planus (either cutaneous or oral).

o. History of oculocutaneous albinism, Neurofibromatosis I (Von Recklinghausen's Disease), Neurofibromatosis II, and tuberous sclerosis.

p. History of photosensitivity, including but not limited to any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria, or any dermatosis aggravated by sunlight, such as lupus erythematosus, porphyria, and xeroderma pigmentosa.

q. History of psoriasis excluding non-recurrent childhood guttate psoriasis.

r. History of chronic radiation dermatitis (radiodermatitis).

s. History of scleroderma.

t. History of chronic urticaria lasting longer than 6 weeks even, if it is asymptomatic when controlled by daily maintenance therapy.

u. Current symptomatic plantar wart(s).

v. Current scars that can reasonably be expected to interfere with properly wearing military clothing or equipment, or to interfere with satisfactorily performing military duty due to pain or decreased range of motion, strength, or agility.

w. Prior burn injury involving 18 percent or more body surface area (including graft sites), or resulting in functional impairment to such a degree, due to scarring, as to interfere with satisfactorily performing military duty due to pain or decreased range of motion, strength, temperature regulation, or agility.

x. Current localized fungal infections, if they can be reasonably expected to interfere with properly wearing military equipment or performing military duties. For systemic fungal infections, refer to Paragraph 5.23.s.

y. History of any medical condition severe enough to warrant use of systemic steroids for greater than 2 months, or any use of other systemic immunosuppressant medications.

z. Conditions with malignant potential in the skin including but not limited to basal cell nevus syndrome, oculocutaneous albinism, xeroderma pigmentosum, Muir-Torre Syndrome, Dyskeratosis Congenita, Gardner Syndrome, Peutz-Jeghers Syndrome, Cowden Syndrome, Multiple Endocrine Neoplasia, Familial Atypical Multiple Mole Melanoma Syndrome, and Birt-Hogg-Dube Syndrome.

aa. History of cutaneous malignancy before the 25th birthday including but not limited to basal cell carcinoma and squamous cell carcinoma. History of the following skin cancers at any age: malignant melanoma, Merkel cell carcinoma, sebaceous carcinoma, Paget's disease, extramammary Paget's disease, microcystic adnexal carcinoma, other adnexal neoplasms, and cutaneous lymphoma including mycosis fungoides.

ab. History of lupus erythematosus.

ac. History of congential disorders of cornification including but not limited to ichthyosis vulgaris, x-linked ichthyosis, lamellar ichthyosis, Darier's Disease, Epidermal Nevus Syndrome, and any palmo-plantar keratoderma.

ad. History of congenitalal disorder of the hair and nails including but not limited to pachyonychia congenita or ectodermal dysplasia.

ae. History of dermatomyositis.

5.22. BLOOD AND BLOOD FORMING SYSTEM.

a. Current hereditary or acquired anemia.

b. History of coagulation defects.

c. Any history of chronic, or recurrent thrombocytopenia.

d. History of deep venous thrombosis or pulmonary embolism.

e. History of chronic or recurrent agranulocytosis or leukopenia.

f. History of chronic polycythemia, chronic leukocytosis or chronic thrombocytosis.

g. Disorders of the spleen including:

(1) Current splenomegaly.

(2) History of splenectomy.

5.23. SYSTEMIC CONDITIONS.

a. History of disorders involving the immune mechanism, including immunodeficiencies.

b. Presence of human immunodeficiency virus or laboratory evidence of infection or false-positive screening test(s) with ambiguous results by supplemental confirmation test(s).

c. Tuberculosis.

(1) History of active pulmonary or extra pulmonary tuberculosis in the previous 2 years or history of active pulmonary or extra-pulmonary tuberculosis without reliable documentation of adequate treatment.

(2) History of latent tuberculosis infection, as defined by current Centers for Disease Control guidelines, unless documentation of completion of appropriate treatment.

d. History of syphilis without appropriate documentation of treatment and cure.

e. History of anaphylaxis. Anaphylaxis is highly likely when any one of the following three criteria are fulfilled:

(1) Acute onset of an illness (minutes to several hours) with involvement of the skin, mucosal tissue, or both (e.g., generalized hives, pruritus or flushing, swollen lips-tongue-uvula) and at least one of the following:

(a) Respiratory compromise (e.g., dyspnea, wheeze-bronchospasm, stridor, reduced peak expiratory flow, hypoxemia); or

(b) Reduced blood pressure (BP) or associated symptoms of end-organ dysfunction (e.g., hypotonia [collapse], syncope, incontinence).

(2) Two or more of the following that occur rapidly after exposure to a likely allergen for that patient (minutes to several hours):

(a) Involvement of the skin-mucosal tissue (e.g., generalized hives, itch-flush, swollen lips-tongue-uvula).

(b) Respiratory compromise (e.g., dyspnea, wheeze-bronchospasm, stridor, reduced peak expiratory flow, hypoxemia).

(c) Reduced BP or associated symptoms (e.g., hypotonia [collapse], syncope, incontinence).