DEPARTMENT OF THE INTERIOR

STANDARD MEDICAL HISTORY AND EXAMINATION FORM

** CAUTION **

WHEN COMPLETED, THIS DOCUMENT CONTAINS CONFIDENTIAL MEDICAL INFORMATION

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** DOI Occupational Health Services Program Manager:** Please: 1) check the box on page 3 to indicate if this is a pre-placement / baseline / exit exam, or a periodic exam, and check all Function and Clearance boxes that apply; 2) enter the three addresses in the spaces below; 3) indicate by checking the correct box (☐ below) for the one to receive the forms once the exam is complete; and 4) deliver the form to the person who is to receive the examination. Also, if the examinee is a new-hire, and a compensated disabled veteran, he/she is to be informed that the following documents must be attached to this form at the time of the examination, and will become part of this record, if he/she wishes consideration as a disabled veteran: copies of a) Rating Sheet; b) Medical Exam for Disability Evaluation (VA-21-2545) or Rating Decision (VA-21-6796b) or detailed documentation on the diagnosis, treatment, and evaluation of his/her compensated disability; and c) specialist reports, if any.

** Person to Receive the Examination (Examinee):** Please see the Privacy Act Notice on page 2 of this form, and note that your signature is required on pages 2 and 10 or the form cannot be processed further. Prior to your examination appointment, please complete ALL of the shaded portions of the following pages of this form, and take the entire packet directly to the EXAMINING PHYSICIAN/CLINIC at the address noted below on the day of your scheduled examination. All positive entries in the medical history sections of the form should be explained fully, and may require further information from your personal physician. Incomplete forms, or those missing information, may result in a delay in clearing you for your assigned functions. This examination does not substitute for periodic health evaluations conducted by your personal health care provider. It is being conducted for occupational purposes only. It is important, however, that you share all of the results of this examination with your personal physician for ongoing care.

** Note #1:** If you are a new-hire, and a compensated disabled veteran, you must attach the following documents to this form at the time of the examination if you wish to have your disabled veteran status considered: copies of a) Rating Sheet; b) Medical Exam for Disability Evaluation (VA-21-2545) or Rating Decision (VA-21-6796b) or detailed documentation on the diagnosis, treatment, and evaluation of your compensated disability; and c) specialist reports, if any.

** Note #2:** You should arrive for your examination in a fasting condition (e.g., no food or drink other than prescribed medications during the 12 hours prior to having your blood drawn at the examination site).

** Examining Physician:** Please complete all of the double-lined portions of the following form, through page 10. Note: Please provide full explanations or clarifying information for all findings that are not completely normal, and assure that the DOI or agency Medical Review Officer is provided all available information so that he/she can carry out DOI’s occupational health review function. When complete, please return this form and any associated forms and reports to the recipient checked below.

☐ DOI OHS PROGRAM MANAGER ☐ MEDICAL REVIEW OFFICER ☐ EXAMINING PHYSICIAN/CLINIC

_________________________________________  _______________________________________
_________________________________________  _______________________________________
_________________________________________  _______________________________________
PRIVACY ACT INFORMATION

The information obtained in the completion of this form is used to help determine whether an individual assigned to a job with duties that may be considered arduous or hazardous can carry out those duties in a safe and efficient manner that will not unduly risk aggravation, acceleration, exaggeration, or permanently worsening pre-existing medical condition(s). The collection and use of this information is consistent with the provisions of 5 USC 552a (the Privacy Act of 1974), 5 USC 3301 (Civil Service examination, certification, and appointment), 5 CFR 339 (Medical Qualification Determinations), and Executive Orders 12107 (authorities for personnel folders) and 12564 (Drug Free Federal Workplace).

This form, along with any attached or associated information, will be placed in your Employee Medical File, and is to be used only for official purposes, as explained and published annually in the Federal Register under OPM/GOVT-10, the Office of Personnel Management system of records notice. Your submission of this information is voluntary. If you do not wish to provide the information, you are not required to do so. However, your assignment to perform duties that are considered arduous or hazardous depends on the availability of complete and current occupational health records. Failure to complete this form according to instructions, or to have the indicated medical examination, may result in a delay in processing or inability to assign you to certain job functions.

REGULATORY AUTHORITY TO REQUEST ADDITIONAL MEDICAL INFORMATION (e.g., from employee’s personal physician)

5 CFR 339.104 Definitions.

For purposes of this part--

Medical documentation or documentation of a medical condition means a statement from a licensed physician or other appropriate practitioner which provides information the agency considers necessary to enable it to make a employment decision. To be acceptable, the diagnosis or clinical impression must be justified according to established diagnostic criteria and the conclusions and recommendations must not be inconsistent with generally accepted professional standards. The determination that the diagnosis meets these criteria is made by or in coordination with a physician or, if appropriate, a practitioner of the same discipline as the one who issued the statement. An acceptable diagnosis must include the following information, or parts identified by the agency as necessary and relevant:

(a) The history of the medical conditions, including references to findings from previous examinations, treatment, and responses to treatment;
(b) Clinical findings from the most recent medical evaluation, including any of the following which have been obtained: Findings of physical examination; results of laboratory tests; X-rays; EKG’s and other special evaluations or diagnostic procedures; and, in the case of psychiatric evaluation or psychological assessment, the findings of a mental status examination and the results of psychological tests, if appropriate;
(c) Diagnosis, including the current clinical status;
(d) Prognosis, including plans for future treatment and an estimate of the expected date of full recovery;
(e) An explanation of the impact of the medical condition on overall health and activities, including the basis for any conclusion that restrictions or accommodations are or are not warranted, and where they are warranted, an explanation of their therapeutic or risk avoiding value;
(f) An explanation of the medical basis for any conclusion which indicates the likelihood that the individual is or is not expected to suffer sudden or subtle incapacitation by carrying out, with or without accommodation, the tasks or duties of a specific position;
(g) Narrative explanation of the medical basis for any conclusion that the medical condition has or has not become static or well stabilized and the likelihood that the individual may experience sudden or subtle incapacitation as a result of the medical condition. In this context, “static or well-stabilized medical condition” means a medical condition which is not likely to change as a consequence of the natural progression of the condition, specifically as a result of the normal aging process, or in response to the work environment or the work itself. “Subtle incapacitation” means gradual, initially imperceptible impairment of physical or mental function whether reversible or not which is likely to result in performance or conduct deficiencies. “Sudden incapacitation” means abrupt onset of loss of control of physical or mental function.

Physician means a licensed Doctor of Medicine or Doctor of Osteopathy, or a physician who is serving on active duty in the uniformed services and is designated by the uniformed service to conduct examinations under this part.

Practitioner means a person providing health services who is not a medical doctor, but who is certified by a national organization and licensed by a State to provide the service in question.

I certify that all of the information I have provided on this form is complete and accurate to the best of my knowledge. Furthermore, consistent with the Privacy Act Notice above, I authorize the release to my employing agency of all information contained on this examination form and all other forms generated as a direct result of my examination (for example, laboratory, spirometry, vision, and audiometry test results, and any history forms completed by me). The information will be used strictly for official purposes, as outlined above.

Examinee’s Signature: Date:
### DOI Occupational Health Services Program – Standard Medical History and Examination Form

The individual to be examined is to complete the shaded medical history portions of this form prior to his/her appointment. The examining physician/clinic is to attach to this form any hard copies of screening, diagnostic, and/or laboratory tests, and send them as a package to the addressee checked on page 1 of this form.

| Name, address, and phone number (including fax) of physician/health center performing examination: | New Applicants ONLY: |
| --- |
|  |
|  |

<table>
<thead>
<tr>
<th>Name of Agency:</th>
<th>Your Current Occupation:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Examinee’s Name:</th>
<th>Position/Job Title:</th>
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<tr>
<th>Address:</th>
<th>SS#</th>
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<tr>
<th>Work Location:</th>
<th>Region:</th>
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<table>
<thead>
<tr>
<th>Home Phone:</th>
<th>Work Phone:</th>
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<tr>
<th>Date of Scheduled Exam:</th>
<th>Date of Birth:</th>
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### DOI OHS PROGRAM MANAGER

**TYPE OF EXAMINATION**

- [ ] Pre-placement/Baseline/Exit
- [ ] Periodic

**SPECIFY FUNCTION AND/OR CLEARANCES REQUESTED**

(Check ALL That Apply)

- [ ] Respirator User [requires completion of the Request for Respirator Clearance form]
- [ ] Law Enforcement (Note #1: A different form for LE officers may be required. Contact the Office of Occupational Health and Safety if you have questions) (Note #2: If indicated, check the box in the lower right corner of page 7 to request these special assessments.)
- [ ] Diver
- [ ] Commercial Drivers License
- [ ] Hazardous Waste Worker
- [ ] Inspector (Off-Shore or Land-Based)
- [ ] Tower Climber
- [ ] Laboratory Worker
- [ ] Other (specify)

### EXAMINING PHYSICIAN (Please Note - Core Exam Must Always be Completed, Plus All Function-Specific Services Shown on Following Page)

<table>
<thead>
<tr>
<th>PRE-PLACEMENT/BASELINE/EXIT CORE EXAM Required Services: (Check those services completed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Authorization for Disclosure Form</td>
</tr>
<tr>
<td>[ ] General Medical History</td>
</tr>
<tr>
<td>[ ] General Physical Examination</td>
</tr>
<tr>
<td>[ ] Chemistry Panel (including Glucose, Bilirubin (total), Cholesterol, HDL-C, LDL-C, Triglycerides, GGTP, LDH, SGOT, SGPT), Complete Blood Count, and Urinalysis</td>
</tr>
<tr>
<td>[ ] Audiology (including noise exposure history)</td>
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<tr>
<td>[ ] Electrocardiogram</td>
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<td>[ ] Spirometry</td>
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<tr>
<td>[ ] Vision Screening (Corrected and Uncorrected Near and Far; Color; Peripheral; Depth Perception)</td>
</tr>
<tr>
<td>[ ] Plus other Function or Clearance-required services (see the following page)</td>
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<table>
<thead>
<tr>
<th>PERIODIC CORE EXAM Required Services: (Check those services completed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Authorization for Disclosure Form</td>
</tr>
<tr>
<td>[ ] General Medical History</td>
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</tr>
<tr>
<td>[ ] Plus other Function or Clearance-required services (see the following page)</td>
</tr>
</tbody>
</table>

Note: For Respirator User exams (see page 4), the General Physical Examination may be a brief, limited exam or a more extensive exam, depending on the health of the examinee and the judgement of the examiner. Also, laboratory tests (e.g., chemistry panel, blood count, and urinalysis) and procedures (e.g., electrocardiograms) are intended to be at the discretion of the examiner, rather than required services. Refer to the DOI Occupational Medicine Program Handbook for further guidance. For all Respirator User exams, completion of the DOI Request for Respirator Clearance form must precede this exam and be attached to this exam form when completed.
<table>
<thead>
<tr>
<th>Function</th>
<th>Pre-Placement/Baseline/Exit Core Exam Services, plus:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Respirator User</strong></td>
<td>DOI Request for Respirator Clearance form (May be a Limited Exam) (Use above for any Respirator User exam)</td>
</tr>
<tr>
<td><strong>Law Enforcement</strong></td>
<td>Tuberculosis skin test (PPD, Mantoux) Maximal, diagnostic, symptom-limited stress EKG using the Bruce Protocol (every 5 yrs. after age 40 and per MRO) Chest X-Ray – PA or PA/Lat (Requires MRO Clearance) Blood lead and Zinc protoporphyrin Periodic Core Exam Services, plus: Vision (Cor. and Uncor. Near/Far; Color; Peripheral; Depth) Audiometry (including noise exposure history) Electrocardiogram Maximal, diagnostic, symptom-limited stress EKG using the Bruce Protocol (every 5 yrs. after age 40 and per MRO) Chest X-Ray – PA or PA/Lat (Requires MRO Clearance) Blood lead and Zinc protoporphyrin (firearm instructor only)</td>
</tr>
<tr>
<td><strong>Tower Climber</strong></td>
<td>Chest X-Ray - PA/Lat Tuberculosis skin test (PPD, Mantoux) Tetanus booster (if needed) Periodic Core Exam Services, plus: Vision (Cor. and Uncor. Near/Far; Peripheral; Depth) Audiometry (including noise exposure history)</td>
</tr>
<tr>
<td><strong>Diver</strong></td>
<td>Pre-Placement/Baseline Core Exam Services, plus: (For age 40 and over) Multiple Risk Factor Assessment (age lipid profile, blood pressure, diabetic screening) Chest X-Ray (PA/Lat) Blood Type and Rh Sickle Cell Prep Periodic Core Exam Services, plus: Vision (Cor. and Uncor. Near/Far) Chest X-Ray (PA/Lat) (every 2 years after age 40) Electrocardiogram (every year after age 35)</td>
</tr>
<tr>
<td><strong>Commercial Drivers License</strong></td>
<td>Pre-Placement/Baseline Core Exam Services, plus: Audiometry (including noise exposure history) Vision (Corr. and Uncorr. Near/Far; Color; Peripheral; Depth)</td>
</tr>
<tr>
<td><strong>Inspector (Off-Shore or Land-Based)</strong></td>
<td>Pre-Placement/Baseline/Exit Core Exam Services, plus: Chest X-Ray - PA/Lat Tuberculosis skin test (PPD, Mantoux) (Offshore Only) Tetanus booster (if needed) (Offshore Only) Periodic Core Exam Services, plus: Vision (Cor. and Uncor. Near/Far; Peripheral; Depth) Audiometry (including noise exposure history) Chest X-Ray - PA/Lat (if indicated, by history or exam) Spirometry (if indicated, by history or exam)</td>
</tr>
<tr>
<td><strong>Large Vessel Crewmember</strong></td>
<td>Pre-Placement/Baseline/Exit Core Exam Services, plus: Vision (best far, cor. and uncorr.; Color; Peripheral) Audiometry (if needed)</td>
</tr>
<tr>
<td><strong>Hazardous Waste Worker</strong></td>
<td>Pre-Placement/Baseline/Exit Core Exam Services, plus: Chest X-ray (PA/Lat) Cholinesterase (RBC/Plasma) Periodic Core Exam Services, plus: Vision (Cor. and Uncor. Near/Far; Color; Peripheral; Depth) Chest X-ray (PA/Lat) (prn) Spirometry Audiometry (including noise exposure history) Cholinesterase (RBC/Plasma) 24 hour Urine Heavy Metal Screen</td>
</tr>
<tr>
<td><strong>Laboratory Worker</strong></td>
<td>Pre-Placement/Baseline/Exit Core Exam Services, plus: Chest X-Ray – PA/Lat Blood lead and Zinc Protoporphyrin (for firearms users) Cholinesterase (RBC/Plasma) Serum, 5cc, labeled, frozen, and stored Immunizations and Screening (see DOI Handbook) Periodic Core Exam Services, plus: Vision (Cor. and Uncor. Near/Far; Color; Peripheral; Depth) Spirometry Audiometry (including noise exposure history) Serum, 5cc, labeled, frozen, and stored Cholinesterase (RBC/Plasma) Blood lead and Zinc Protoporphyrin (for firearms users) Immunizations and Screening (see DOI Handbook)</td>
</tr>
<tr>
<td><strong>Large Vessel Crewmember</strong></td>
<td>Pre-Placement/Baseline/Exit Core Exam Services, plus: Vision (best far, cor. and uncorr.; Color; Peripheral) Audiometry (if needed)</td>
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</tbody>
</table>
**PAST MEDICAL HISTORY**

(Please complete this page if this is your first time using this form, or if you are unsure if you have completed it before.)

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Have you ever been treated for a mental or emotional condition? (If Yes, specify when, where, and give details.)</td>
<td></td>
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<tr>
<td>B. Have you had or have you been advised to have any operation? (If Yes, specify when, and give details.)</td>
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<tr>
<td>C. Have you ever been a patient in any type of hospital after infancy? (If Yes, specify when, where, and give details.)</td>
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<tr>
<td>D. Have you ever been treated with an organ transplant, prosthetic device (e.g., artificial hip), or an implanted pump (e.g., for insulin) or electrical device (e.g., cardiac defibrillator)? (If Yes, please describe fully, and provide copies of pertinent medical records.)</td>
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<tr>
<td>E. Have you ever had any other serious illness/injury? (If yes, specify when, where, and give details.)</td>
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<tr>
<td>F. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past year for other than minor illness? (If Yes, specify when, where, and give details.)</td>
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<tr>
<td>G. Have you ever been rejected for military service or discharged from military service because of physical, mental, or other health reasons? (If Yes, give date and reason for rejection.)</td>
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<td>H. Have you ever received, is there pending, or have you applied for a pension or compensation for a disability? (If Yes, specify what kind, granted by whom, what amount, when, and why.)</td>
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</tbody>
</table>

Every item checked “Yes” must be explained below or on the back of this form.

**WELLNESS/HEALTH PROFILE**

**Smoking History**

- Current Smoker
  - Number of cigarettes per day
  - Number of cigars per day
  - Number of pipe bowls per day
  - Total years you have smoked

- Former Smoker
  - Years since quitting
  - Number of cigarettes per day
  - Number of cigars per day
  - Number of pipe bowls per day
  - Total years you smoked

**Alcohol/Drug Use**

What is your average alcohol consumption (number) in a week? __________ Drinks

(1 drink = 12 oz. beer, 1 glass wine or 1.5 oz liquor)

When do you drink alcohol?

- Weekdays
- Weekends
- Both
- Don’t drink

**RESPIRATOR CLEARANCE QUESTIONS**

- Have you ever used a respirator? Yes □ No □
- Will you use one in the coming year? Yes □ No □
- What hazards may be present during your use of a respirator?
  - High altitude
  - Temperature extremes
  - Confined spaces

- Have you ever had, or do you now have any of the following?
  - Persistent cough or shortness of breath
  - Unexplained general weakness or fatigue
  - Asbestosis or silicosis
  - Lung cancer
  - Broken ribs or chest injury
  - Chest pain on deep inspiration
  - Sensation of smothering when using a respirator
  - Heat exhaustion or heat stroke
  - Trouble smelling odors
  - Difficulty squatting
  - Difficulty climbing stairs or ladder carrying 25# weight
  - Other conditions that might interfere with respirator use or result in limited work activity

(Discuss all “Yes” responses with the examining physician.)

Fully explain all medical problems identified in Respirator Clearance Questions section.

**MEDICATIONS**

List all medications (prescription and over-the-counter) you are currently taking.

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**Describe Your Physical Activity or Exercise Program**

(check one)

- Intensity: Low □ Moderate □ High □
- Duration, in Minutes per Session
- Describe activity ____________________________________________
- Frequency _____ Days per week

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Page 5 of 10
## Medical History

### Vascular

- Do you have any vascular (blood vessel) disease?
- Enlarged superficial veins, phlebitis, or blood clots?
- Anemia?
- Hardening of the arteries?
- High Blood Pressure?
- Heart failure?
- Stroke or Transient Ischemic Attack (TIA)?
- Aneurysms (Dilated arteries)?
- Poor circulation or swelling of the hands or feet?
- White fingers with cold or vibration?

### Cardio/Pulmonary

#### Pulmonary Function Testing

(Please attach copy)

- Calibration Date
- (Should be same day as test)
- Machine Brand

#### Comments/Findings on Vascular / Respiratory / Heart sections

### Respiratory

- Do you have any respiratory (lung/airway) disease?
- Asthma (including exercise induced asthma)?
  - (Do you use an inhaler?)
- Bronchitis?
- Emphysema?
- Acute or chronic lung infections?
- Persistent or recurring coughing or wheezing?
- Wind pipe or lung surgery?
- Collapsed lung?
- Scoliosis (curved spine) with breathing limitations?
- History of Tuberculosis?
  - Previous positive TB skin test?
    - Date:

### Heart

- Do you have any heart disease?
- Heart pain (Angina)?
- Heart rhythm disturbance or palpitations (irregular beat)?
- History of Heart Attack?
- Organic heart disease (including prosthetic heart valves, mitral stenosis, heart block, heart murmur, mitral valve prolapse, pacemakers, Wolf Parkinson White (WPW) Syndrome, etc.)?
- Heart surgery?
- Sudden loss of consciousness?
- Other (specify)?

### Chest X-Ray

- Last PA Chest X-ray: Date
- Result: [ ] Normal [ ] Abnormal
- Comments:
- TB Mantoux (PPD) Date: __________ mm Induration:

### Vital Signs

- Height ________ (inches) Weight ________ (pounds)
- Blood Pressure ________ / ________ mm/hg
- Pulse ________ /MIN
  - (Conduct vital sign measurements while sitting; if elevated, repeat in 15 min.)

### Immunizations

- Last Tetanus (Td) Shot (Date):
  - Given today? [ ] Yes [ ] No
- Hepatitis B Vaccine?
  - Has client received? [ ] Yes [ ] No [ ] Declined [ ] Not Applicable
- Hep B series complete? [ ] Yes [ ] No
  - When?
  - Date Immunization #1:______   #2:______   #3:______
- Hepatitis A Vaccine?
  - Has client received? [ ] Yes [ ] No [ ] Declined [ ] Not Applicable
- Hep A series complete? [ ] Yes [ ] No
  - Date Immunization #1:______   #2:______

### Coronary Risk Factors

- Blood Pressure ≥ 145/90
- Fasting Glucose ≥ 120 mg/dl
- Total Cholesterol ≥ 200 mg/dl
- Obesity
- No regular exercise program
- Currently smoking or ≥ pack/yr history
### MEDICAL HISTORY

#### ENDOCRINE
- Do you have any endocrine (hormone) disease? [□][□][□]
- Diabetes (insulin requiring; units per day blank)? [□][□][□]
  - (Year of diagnosis blank)
- Diabetes (non-insulin requiring)? [□][□][□]
  - (Year of diagnosis blank)
- Childhood Onset Diabetes? [□][□][□]
- Thyroid Disease? [□][□][□]
- Obesity? [□][□][□]
- Unexplained weight loss or gain? [□][□][□]

#### OBSTETRIC
- Are you currently pregnant? [□][□][□]
  - *Male; question not applicable*

#### MENTAL HEALTH
- Do you have any psychiatric or mental health problems? [□][□][□]
  - History of psychosis? [□][□][□]
  - Psychiatric/psychological consultation? [□][□][□]
  - Difficulty dealing with stress? [□][□][□]
  - Panic attacks, hyperventilation, or anxiety or phobia disorder? [□][□][□]
  - Periods of uncontrollable rage? [□][□][□]
  - Claustrophobia? [□][□][□]
  - Diagnosed depression, personality disorder, or neuroses? [□][□][□]

#### DERMATOLOGY/ALLERGY
- Do you have any skin or allergy diseases? [□][□][□]
  - Sun sensitivity? [□][□][□]
  - Allergic dermatitis to rubber or latex? [□][□][□]
  - History of chronic dermatitis? [□][□][□]
  - Active skin disease or infections? [□][□][□]
  - Moles that have changed in size or color? [□][□][□]
  - Allergies, including hay fever? (If so, to what?) [□][□][□]

#### MUSCULOSKELETAL
- Do you have any muscle or bone disease? [□][□][□]
  - Moderate to severe joint pain, arthritis, tendonitis? [□][□][□]
  - Amputations? [□][□][□]
  - Loss of use of arm, leg, fingers, or toes? [□][□][□]
  - Loss of sensation? [□][□][□]
  - Loss of strength in hands, arms, legs or feet? [□][□][□]
  - Loss of coordination? [□][□][□]
  - Back injury? [□][□][□]
  - Chronic back pain? (back pain associated with neurological deficit or leg pain) [□][□][□]
  - Are you RIGHT [□] or LEFT [□] handed? (check one)

#### Musculoskeletal
- Normal [□] Abnormal [□]
  - Upper extremities (strength) [□][□][□]
  - Upper extremities (range of motion) [□][□][□]
  - Lower extremities (strength) [□][□][□]
  - Lower extremities (range of motion) [□][□][□]
  - Feet [□][□][□]
  - Hands [□][□][□]
  - Spine, other musculoskeletal [□][□][□]
  - Flexibility of neck, back, spine, hips, knees [□][□][□]

#### Please assess the following, if box is checked: [□]
- Medically cleared to perform the following:
  - Vigorous aerobic exercise program 3 hr/wk [□][□][□]
  - Push ups [□][□][□]
  - Pull ups [□][□][□]
  - Sit ups [□][□][□]
  - One and one half mile (1 1/2) timed run [□][□][□]
  - 3-mile timed walk [□][□][□]
  - Squat/raise w/o holding on; hold squat 45 sec. [□][□][□]
  - Kneel on one knee, arms extended for 7 sec. [□][□][□]
  - Assume a 1 then 2 knee kneeling position within 2 seconds, rise without assistance, repeat [□][□][□]

Comments/Findings

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*Male; question not applicable*
<table>
<thead>
<tr>
<th>MEDICAL HISTORY</th>
<th>DIAGNOSTIC AND PHYSICAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NEUROLOGICAL</strong></td>
<td><strong>GASTROINTESTINAL</strong></td>
</tr>
<tr>
<td>Do you have any neurological disease?</td>
<td>Do you have any stomach or intestinal disease?</td>
</tr>
<tr>
<td>Tremors, shakiness?</td>
<td>Hernias?</td>
</tr>
<tr>
<td>Seizures (recent or previous)?</td>
<td>Colostomy?</td>
</tr>
<tr>
<td>Spinal Cord Injury?</td>
<td>Persistent stomach/abdominal pain or heartburn?</td>
</tr>
<tr>
<td>Numbness or tingling?</td>
<td>Active ulcer disease?</td>
</tr>
<tr>
<td>Head/spine surgery?</td>
<td>Hepatitis or other liver disease?</td>
</tr>
<tr>
<td>History of head trauma with persistent deficits?</td>
<td>Irritable bowel syndrome?</td>
</tr>
<tr>
<td>Chronic recurring headaches (migraine)?</td>
<td>Rectal bleeding?</td>
</tr>
<tr>
<td>Brain tumor?</td>
<td>Vomiting blood?</td>
</tr>
<tr>
<td>Loss of memory?</td>
<td><strong>GENITOURINARY</strong></td>
</tr>
<tr>
<td>Insomnia (difficulty sleeping)?</td>
<td>Do you have any disease of the urinary system or genitals?</td>
</tr>
</tbody>
</table>

**Neurological**
- Normal
- Abnormal
- Cranial Nerves (I - XII)
- Cerebellum
- Motor/Sensory (include vibratory and proprioception)
- Deep Tendon reflexes
- Mental Status Exam

**Gastrointestinal**
- Normal
- Abnormal
- Auscultation
- Palpation
- Organo-megaly
- Tenderness
- Inguinal hernia

**Genitourinary**
- Normal
- Abnormal
- Urogenital exam

(Attach urinalysis report, if done.)

**Comments/Findings**
### Medical History

**Vision**
- Do you have any vision problems or eye disease? (Yes/No)
- Frequent headaches? (Yes/No)
- Blurred vision? (Yes/No)
- Loss of vision in either eye? (Yes/No)
- Eye irritation when using a respirator or goggles? (Yes/No)
- Difficulty reading? (Yes/No)
- Eye disease, glaucoma? (Yes/No)
- Eyeglasses? (Yes/No)
- Contact lenses? (Yes/No)
- Cataracts? (Yes/No)
- Color blindness? (Yes/No)
- Have you had any type of eye surgery (e.g., radial keratotomy, PRK [laser], cataract, etc.)? If “YES”, please provide specific type and date of surgery:

**Hearing**
- Do you have any hearing problems or ear disease? (Yes/No)
- Exposure to loud, constant noise or music in the last 14 hours? (Yes/No)
- Exposure to loud, impact noise in past 14 hours? (Yes/No)
- Ringing in the ears? (Yes/No)
- Difficulty hearing? (Yes/No)
- Ear infections or cold in the last 2 weeks? (Yes/No)
- Dizziness or balance problems? (Yes/No)
- Do you use a hearing aide? (Yes/No)
- Are you in a Hearing Conservation Program? (Yes/No)
- Do you use protective hearing equipment? (Yes/No)
  - If yes, type(s): foam, pre-mold/plugs, ear muffs
- Have you had prior Military Service? (Yes/No)
- Have you had prior ear surgery? (Yes/No)
- Have you had recurrent ear infections? (Yes/No)

### Diagnostic and Physical Findings

**Head and Neck**
- Normal
- Abnormal
  - Head, Face, Neck (thyroid), Scalp
  - Nose/Sinus/Esphageal tube
  - Mouth/Throat
  - Pupils equal/reactive
  - Ocular Motility
  - Ophthalmoscopic Findings
  - Speech

**Ears**
- Right
  - Normal
  - Abnormal
    - Canal/External ear
    - Tympanic Membrane
- Left
  - Normal
  - Abnormal
    - Canal/External ear
    - Tympanic Membrane

**Color Vision**
- Normal
  - Abnormal
  - Number Corrected:
    - Can see Red/Green/Yellow? (Yes/No)
  - Type of test:
    - Ishihara plate
    - Function test (Yarn, wire, etc.)
  - Other (specify)

**Tonometry**
- Right _____ mm/Hg
- Left _____ mm/Hg

**Visual Acuity**
- Corrected vision (Snellen Units)
  - Both Near 20/____
  - Right Near 20/____
  - Left Near 20/____
  - Both Far 20/____
  - Right Far 20/____
  - Left Far 20/____
- Uncorrected vision (Snellen Units)
  - Both Near 20/____
  - Right Near 20/____
  - Left Near 20/____
  - Both Far 20/____
  - Right Far 20/____
  - Left Far 20/____

**Peripheral Vision**
- Right
  - Nasal_____degrees
  - Temporal_____degrees
- Left
  - Nasal_____degrees
  - Temporal_____degrees

**Depth Percepcion**
- Type of test: ___________
  - Normal
  - Abnormal
  - Number Corrected:
    - _____ of _____ tested
  - Interpretation: _____ Seconds of Arc

**Hearing**
- Audiogram Type:
  - Baseline
  - Annual
  - Termination
- Calibration Method:
  - Oscar
  - Biological
- Frequency
  - 500Hz
  - 1000Hz
  - 2000Hz
  - 3000Hz
  - 4000Hz
  - 6000Hz
  - 8000Hz
  - Right ear
  - Left ear
- Review/compare with baseline: No Change, Mild Change, Change of 10 dB ave. or more in 2000, 3000, and 4000 Hz
  - Normal
  - Abnormal
  - Explain: 

---

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### Professional Staff

Please check all the topics you discussed during the diagnostic work-up or physical examination.

- **Diet**
  - Low-calorie
  - Low-fat
  - Low-salt
- **Cholesterol**
- **Hypertension**
- **Exercise**
- **Obesity**
- **Smoking Cessation**
- **Avoid Sun Exposure/Sun Screen**
- **Alcohol Use**
- **Cancer Screening**
- **Immunizations**
- **Hearing Protection**
- **Vision Referral**
- **Other Personal Protective Equipment**
- **Job Stressors**
- **Referral(s)**
- **Others**

### Examining Physician: Workplace Exposure Monitoring

- Is workplace monitoring data or other exposure data for this employee or this position available for your review?
  - Yes
  - No

If yes, what type of data is available?
- Acute Exposure Data
- Periodic Exposure Data
- Ongoing Workplace Monitoring Data
- Individual Dosimetry Data
- Material Safety Data Sheets

How was data made available?
- Electronic Database
- Hard Copy Report
- Employee Self-Report

If exposure data was available, please explain what changes, if any, were made in the examination due to this data:

Based upon your knowledge of the physical demands of the position and/or the potential exposure to occupational hazards, please answer the following:

Does the employee need to be in a medical surveillance program?
- Yes
- No
- Cannot determine based on information available
- Other

### Impression:

1) 
2) 
3) 
4) 
5) 

### Plan:

1) 
2) 
3) 
4) 
5) 

### Signatures

**Nurse**

**Examining Physician**

I have had the examination findings explained to me. I understand these explanations and recommendations, and understand that this examination does not substitute for periodic health evaluations conducted by my personal physician; it has been conducted for occupational purposes only. I have received a copy of the examination results to share with my personal physician:  
- Yes
- No

**Examinee (person having the examination):**

---

Please be sure all required sections of this form have been completed and are legible, and all indicated signatures have been entered, before returning it for review by the designated agency reviewing medical officer. Thank you.
DEPARTMENT OF THE INTERIOR
OCCUPATIONAL HEALTH SERVICES PROGRAM

Medical Review Officer’s Qualification Statement
(to be completed only by the designated reviewing physician for this agency)

Name of Examined Individual: ____________________________________________
SS#: _______________________________________________________________
Date of Birth: ___________________________ Physician/Clinic Address: __________
Physician/Clinic Phone: ___________________________

POSITION(S) OR FUNCTION(S) FOR WHICH CLEARANCE(S) HAVE BEEN REQUESTED
[please check all that apply]

<table>
<thead>
<tr>
<th>Functional Clearance Area</th>
<th>Pre-placement / Baseline / Exit</th>
<th>Periodic</th>
<th>Functional Clearance Area</th>
<th>Pre-placement / Baseline / Exit</th>
<th>Periodic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respirator Use</td>
<td>[ ]</td>
<td>[ ]</td>
<td>Hazardous Waste Work</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>[ ]</td>
<td>[ ]</td>
<td>Inspector</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Diver</td>
<td>[ ]</td>
<td>[ ]</td>
<td>Tower Climber</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Laboratory Worker</td>
<td>[ ]</td>
<td>[ ]</td>
<td>Other (specify: ___________)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Commercial Driver’s License</td>
<td>[ ]</td>
<td>[ ]</td>
<td>Other (specify: ___________)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

This review is based on:
☐ Report of Medical Examination, Dated: ____________________________
☐ Supplemental Medical Information, Dated: ____________________________

Findings:
☐ No Significant Findings - Individual meets the Department’s medical standards for the function(s) / clearance(s) requested.
☐ A Final Determination Cannot be Made Based on Available Medical Information – The following results were inconclusive and require further information or additional testing. Final recommendations cannot be made until this has been completed. The requested information should be provided within 30 days of the review date to the Medical Review Officer at the address noted at the bottom of this page.

☐ Significant Medical Findings - The individual does not meet the Department’s medical standards for the safe and efficient performance of the duties of the function(s) / clearance(s) requested.

Date of Initial Medical Review: ____________________________
Reviewing Physician: ____________________________
Date of Final Medical Review: ____________________________
Signature: ____________________________
Reviewer’s Address: ______________________________________________________________________________________