

NOAA Health Services Questionnaire

Name _____ E-Mail: _____
 _____ Program _____
 Last First Mi. Position _____
 Birth Date: _____ Sex: M F Scientist Teacher-at-Sea Other
 mm/dd/yy
 Work Address _____ Phone _____ (W)
 _____ (H)
 Cruise dates: _____ SSN: _____
 Citizenship: _____ Passport No. _____
 Next of kin: _____ Next of kin relationship: _____
 Address of next of kin: _____
 Emergency Contacts (name and phone no.):
 #1 _____ #2 _____
 Medical Insurance Company: _____ Policy No. _____

HEALTH INFORMATION

General State of Health: Excellent Good Fair Poor
 Presently under the care of a physician? No Yes
 Month/Year of most recent Physical Exam? _____ (mm/yy)
 Month/Year of most recent Chest X-Ray: _____ (mm/yy) Result _____

List current medications (prescription and non-prescription):

None 1. _____ 4. _____
 2. _____ 5. _____
 3. _____ 6. _____

List Allergies:

	Allergy	Reaction
None	1. _____	_____
	2. _____	_____
	3. _____	_____
	4. _____	_____

List ALL active health problems:

None 1. _____
 2. _____
 3. _____
 4. _____

Major Surgeries / Hospitalizations / Emergency Room visits

	Year	Reason
None	1. _____	_____
	2. _____	_____
	3. _____	_____
	4. _____	_____

List Any Dietary Restrictions: Restriction

	Restriction	Reason
None	1. _____	_____
	2. _____	_____

Name: _____

GENERAL SCREENING

As an adult, have you had or experienced?

	No	Yes		No	Yes
Cancer			Severe Depression		
Tuberculosis			Paralysis		
Asthma			Epilepsy		
Hepatitis			Impaired Mobility		
Chronic Cough			Severe Hearing Loss		
Coughed up Blood			Severe Visual Impairment		
Recent unexplained weight gain or loss of 20 or more lbs.			Periods of Unconsciousness		
Female only: Are you pregnant?			Severe Motion Sickness		
			Date of last menstrual period _____		

Please explain all YES answers below or on continuation sheet:

CARDIAC SCREENING

As an adult, have you had or experienced?

	No	Yes		No	Yes	(and value if known)
Abnormal ECG			Hypertension			recent reading _____
Sedentary Life Style			Diabetes			HgA _{1c} _____
Family History of Heart Attack before age 45			High Cholesterol			recent reading _____
Heart Attack			Tobacco Use			packs/day _____
Shortness of Breath			Prolonged Chest Pain			
			Fainting spells/Syncope			

Please explain all YES answers below or on continuation sheet:

Name: _____

IMMUNIZATION SCREENING

Please list the date(s) you obtained immunizations/prophylaxis against the following diseases:

PPD (TB test) - must be within last 12 months:	Date _____	Result _____		
	Date	Type	Date unknown	None
Tetanus ¹	_____		_____	_____
Hepatitis A Series: Dose 1	_____		_____	_____
Dose 2	_____		_____	_____
Hepatitis B Series: Dose 1	_____		_____	_____
Dose 2	_____		_____	_____
Dose 3	_____		_____	_____
Cholera	_____		_____	_____
Diphtheria ¹	_____		_____	_____
Influenza (most recent)	_____		_____	_____
Immunoglobulin (IG)	_____		_____	_____
Malaria	_____	_____	_____	_____
Measles, Mumps, Rubella (MMR)	_____		_____	_____
Polio	_____	_____	_____	_____
Typhoid Fever	_____		_____	_____
Yellow Fever	_____		_____	_____

Other: Please provide complete information on Continuation Sheet

¹May be given as part of TD vaccination

Are you aware of any other medical condition(s) that may affect your suitability for sea duty? No Yes

If yes, please explain on the continuation page

If you have any questions, please contact the appropriate Health Services Office:

Marine Operations Atlantic (757) 441-6320 Marine Operations Pacific (206) 553-8704

Continuation page attached? No Yes

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

Signature

Date (mm/dd/yy)

Forward to the following ships: 1. _____ 2. _____ 3. _____

MEDICALLY CLEARED FOR SEA DUTY BY HISTORY YES NO NEED MORE INFO

MOA/ MOP Regional Director of Health Services

Date (mm/dd/yy)

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NOAA Health Services Questionnaire Continuation Page

Name: _____