Appendix H (4/2006)

NOAA Health Services Questionnaire

Name _____
Last First Mi.

E-Mail: _____
Program _____
Position _____
Scientist Teacher-at-Sea Other

Birth Date: _____ Sex: ☐ M ☐ F
mm/dd/yy

Work Address _____
_____

Phone _____ (W)
_____ (H)

Cruise dates: _____
Citizenship: _____
Next of kin: _____

SSN: _____
Passport No._____
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	Reason
None ☐ 1.	_____	_____
2.	_____	_____

Reset form

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			Periods of Unconsciousness	☐	☐
or loss of 20 or more lbs.	☐	☐	Severe Motion Sickness	☐	☐
Female only: Are you pregnant?	☐	☐	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			High Cholesterol	☐	☐	recent reading _____
Attack before age 45	☐	☐	Tobacco Use	☐	☐	packs/day _____
Heart Attack	☐	☐	Prolonged Chest Pain	☐	☐	
Shortness of Breath	☐	☐	Fainting spells/Syncope	☐	☐	

Please explain all YES answers below or on continuation sheet:

NOAA Health Services Questionnaire

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 _____ ☐ Negative ☐ Positive (millimeters) ___

	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

[1]May 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)

NOAA Health Services Questionnaire Continuation Page

Name: _____