Print Form

NATIONAL SCIENCE FOUNDATION - POLAR PHYSICAL EXAMINATION

MEDICAL HISTORY

Complete pages 1-8 in ink prior to Dr.'s exam

Polar Medical Staff Use Only

Date: ______________ ☐ PQ ☐ PQ Summer Only ☐ NPQ

Medical Condition(s):

Restrictions and Follow-up:

____

____

Reason for NPQ:

____

____

Polar Medical Staff Use Only

Reviewed by:_________

Date: ____________

Name: last, first, middle (must match passport)	Age:	Birth date (YY/MM/DD):	Sex ☐ F ☐ M

Nickname (aka)	Maiden Name	Previous Name or Other Legal Name:

Street	City	State	Zip

Telephone (include area code):

Day: Evening: Mobile: E-Mail:

Emergency Point of Contact (Name, Address and Phone Number):

Job Title:	Current Deployment Dates: From ____________ to ____________	Previous Polar (Arctic or Antarctic) Deployment? Dates: ____________ Location: ____________

Affiliation: ☐ NSF

- ☐ Science Event #_______
- ☐ Technical Event #______
- ☐ RPSC
- ☐ VECO
- ☐ Other:____________

Proposed Antarctic Season and Worksite:

- ☐ Summer (Sep-Feb)
- ☐ Winter (Mar-Oct)
- ☐ Winfly ____________ (dates)
- ☐ McMurdo Station
- ☐ South Pole Station
- ☐ Palmer Station
- ☐ RV/NB Palmer
- ☐ RV/LM Gould
- ☐ Field Camp ____________
- ☐ Other: ____________

Proposed Arctic Season and Worksite:

- ☐ Summer (Mar-Sep)
- ☐ Winter (Oct-Feb)
- ☐ Summit
- ☐ Alaska____________
- ☐ USCGC Healy
- ☐ Field Camp ____________
- ☐ Other:____________

MEDICAL HISTORY (continued)

NAME________________________________ DOB ______________________

FAMILY MEDICAL HISTORY****DO NOT USE FOR YOUR OWN HEALTH HISTORY****		
Relationship	Status of Health and Age, if living	Age and Cause of Death
Father		
Mother		
Spouse		
Brothers/Sisters/Children (list below):		

Family History: Check box, If yes, who? (Explain.):			Relationship
Diabetes?	☐ YES	☐ NO	
Insulin Required?	☐ YES	☐ NO	
Heart Attack? Age? _____________	☐ YES	☐ NO	
Stroke? Age? _____________	☐ YES	☐ NO	
Bleeding Disorder? Describe: (Hemophilia, Clotting Factor Deficiency) ______________________	☐ YES	☐ NO	
Autoimmune Disorder? Describe: (Rheumatoid Arthritis, Lupus, Other) _______________	☐ YES	☐ NO	
Hemoglobin disorder? Describe: (Sickle Cell, Thalassemia, etc.)	☐ YES	☐ NO	

Family History: Check box, If yes, who? (Explain.):			Relationship
Kidney Disease? Describe:	☐ YES	☐ NO	
Cancer? Type? Treatment?	☐ YES	☐ NO	
Stomach/GI Disease? Type? ______________________ ______________________	☐ YES	☐ NO	
Mental Health Disorders? Describe: (i.e., Depression, Bipolar, Suicide, Schizophrenia) ______________________	☐ YES	☐ NO	

MEDICAL HISTORY (continued) NAME________________________________ DOB _______________________

PERSONAL MEDICAL HISTORY (ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY)

Do you have any allergies to medications? ☐ YES ☐ NO If yes, which ones?

Do you have any other known allergies? ☐ YES ☐NO If yes, describe (including your reaction).

Medications**:** List all you take, including Over-the-Counter Medications and Vitamins:

Name of Medication	Dose	How Often Taken - daily, twice daily, as needed, etc.

Surgeries/Hospitalizations - List all surgeries and dates (include any outpatient surgery): If more space is needed, use back or add a sheet.

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY			ADDITIONAL COMMENTS
1 **Neurological Disorder?**			
a. Multiple Sclerosis	☐ YES	☐ NO	
b. Fibromyalgia	☐ YES	☐ NO	
c. Other Nerve/Muscle Disorders? (Describe.) ______________________________	☐ YES	☐ NO	
d. Seizure disorder? Date of Last Seizure:_________________	☐ YES	☐ NO	
e. Head Injury? Loss of Consciousness - Date_______________ How Long_________________	☐ YES	☐ NO	
2 **Headaches**?	☐ YES	☐ NO	
Migraines ? Date Diagnosed_________________ Date of last Migraine_____________	☐ YES	☐ NO	
3 **Do you have diabetes**? Date diagnosed:_______________ Controlled by: ☐Insulin ☐Oral medication ☐Diet Last Emergency Room visit:__________________	☐ YES	☐ NO	
4 **Do you have Cholesterol disorders? Date diagnosed:______________ Controlled by: ☐Oral medication ☐Diet**	☐ YES	☐ NO	
5 **Do you have Thyroid Disease? Explain, if Yes - include medication**	☐ YES	☐ NO	
Surgery required? When?____________________	☐ YES	☐ NO	

NAME______________________________ DOB ______________________

PERSONAL MEDICAL HISTORY (continued)

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY				ADDITIONAL COMMENTS
6	**Vision:** Do you wear glasses?	☐ YES	☐ NO	
	contacts?	☐ YES	☐ NO	
	Do you have unequal pupils?	☐ YES	☐ NO	
	Do you have blindness in one or both eyes?	☐ YES	☐ NO	
	Do you have Glaucoma?	☐ YES	☐ NO	
	Do you have Cataracts	☐ YES	☐ NO	
	Do you have Double Vision?	☐ YES	☐ NO	
	Do you have other vision problems? Describe:	☐ YES	☐ NO	
7	**Dizziness/Fainting** Reason: Date of occurrence:_____________________	☐ YES	☐ NO	
8	**Do you have ear, nose, or throat problems?** Describe:	☐ YES	☐ NO	
		☐ YES	☐ NO	
	Hearing Impairment?	☐ YES	☐ NO	
	Hayfever?	☐ YES	☐ NO	
	Are you currently taking allergy shots?			
9	**Do you have any Pulmonary Disease?**	☐ YES	☐ NO	
	Chronic Obstructive Pulmonary Disease (COPD)?	☐ YES	☐ NO	
	Pulmonary Embolism/Blood Clots?	☐ YES	☐ NO	
	Sleep Apnea?	☐ YES	☐ NO	
	Asthma?	☐ YES	☐ NO	
	Date of last attack___________________			
	Number of attacks in past year_________	☐ YES	☐ NO	
	Hospitalizations?	☐ YES	☐ NO	
	Nebulizer treatment in the past year?			
	How often?___________________________			
	Emphysema or chronic Bronchitis or Bronchiectasis?	☐ YES	☐ NO	
	Shortness of Breath of Difficult Breathing? Explain:	☐ YES	☐ NO	
	Tuberculosis History of positive TB skin test Have you ever received BCG?	☐ YES	☐ NO	
	Have you ever experienced altitude sickness? At what altitude_______________ Describe treatment:	☐ YES	☐ NO	

NAME________________________________ DOB ________________________

PERSONAL MEDICAL HISTORY (continued)

	ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY			**ADDITIONAL COMMENTS**
10	**Do you have Heart Problems/Disease?**	☐ YES	☐ NO	
	Previous Heart Attack?	☐ YES	☐ NO	
	Angina/Chest Pain? Describe (include frequency, precipitating factors, and treatments): ____________________________ ____ ____	☐ YES	☐ NO	
	Congestive Heart Failure (CHF)?	☐ YES	☐ NO	
	Supraventricular Tachycardia (SVT)? Date diagnosed__________________ Frequency and treatment:____________________ ____	☐ YES	☐ NO	
	Atrial Fibrillation? Date diagnosed__________________	☐ YES	☐ NO	
	Heart Murmur/Valvular Heart Disease? Date diagnosed__________________ Limitations:	☐ YES	☐ NO	
	☐**Angiogram** ☐**Angioplasty** ☐**Stent** ☐**Cardiac Bypass Surgery** Date__________________	☐ YES	☐ NO	
	Pacemaker?	☐ YES	☐ NO	
	Hypertension? Date diagnosed__________________	☐ YES	☐ NO	
	TIA/Stroke? Date __________________	☐ YES	☐ NO	
	History of Deep Vein Thrombosis (DVT)/Blood Clots?	☐ YES	☐ NO	
	History of Abdominal or Cerebral Aneurysm?	☐ YES	☐ NO	
11	**Arthritis?**	☐ YES	☐ NO	
	Type: ____________________			
	Permanent disability?	☐ YES	☐ NO	
12	**Do you have Gout?** If so, describe your treatment plan	☐ YES	☐ NO	
13	**Have you ever used tobacco/tobacco products?**	☐ YES	☐ NO	
	Do you currently use tobacco/tobacco products?	☐ YES	☐ NO	
	Type of use ☐cigarettes ☐cigar ☐pipe ☐chew			
	Packs per week? __________			
	If you've quit, last year of use_______________			
	Number of years of tobacco use in past ____________			

PERSONAL MEDICAL HISTORY (continued)

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY				ADDITIONAL COMMENTS
14	**Have you had an Exercise Stress Test/Treadmill?**	☐ YES	☐ NO	
	If yes, when?_____________________________			
15	**Do you have a regular exercise program?**	☐ YES	☐ NO	
	Describe:			
16	**Have you had Stomach/Bowel Problems?**	☐ YES	☐ NO	
	Anemia	☐ YES	☐ NO	
	Black tarry stools	☐ YES	☐ NO	
	Blood in stools	☐ YES	☐ NO	
	Frequent or persistent diarrhea	☐ YES	☐ NO	
	Gallbladder Problems/Stones	☐ YES	☐ NO	
	Heartburn	☐ YES	☐ NO	
	Hemorrhoids	☐ YES	☐ NO	
	Inflammatory bowel disease (Crohns/Ulcerative Colitis)	☐ YES	☐ NO	
	Ulcers	☐ YES	☐ NO	
	Date of last flare up______________________			
17	**Have you been diagnosed with liver problems?**	☐ YES	☐ NO	
	Hepatitis?	☐ YES	☐ NO	
	Type ☐A ☐B ☐C ☐Other_______________			
	Hepatitis vaccine	☐ YES	☐ NO	
	Dates: ____________ (first) _______________ (second) ____________ (third)			
18	**Do you have Kidney problems?**	☐ YES	☐ NO	
	History of Kidney Stones?	☐ YES	☐ NO	
	Polycystic Kidney Disease?	☐ YES	☐ NO	
	Frequent Urinary Tract Infections?	☐ YES	☐ NO	
19	**Do you have a history of Hernias?**	☐ YES	☐ NO	
	Date___________________			
	Location______________________________________			
20	**Have you had any sexually transmitted diseases?**	☐ YES	☐ NO	
	When? _______________________			
	Type: ☐Herpes ☐Chlamydia ☐Gonorrhea ☐Syphillis ☐Other Specify)________________			
	Treated?	☐ YES	☐ NO	
	When? ______________________			
	Describe:			
21	**Cancer or leukemia?**	☐ YES	☐ NO	
	Type/Location:_______________________________			
	Date diagnosed______________________________			
	Surgery	☐ YES	☐ NO	
	Chemotherapy	☐ YES	☐ NO	
	Radiation Therapy	☐ YES	☐ NO	
	Other Treatment:___________________________	☐ YES	☐ NO	
22	**Skin rash/Disease?**	☐ YES	☐ NO	
	Describe (include duration and treatment):			

NAME______________________________ DOB ______________________

PERSONAL MEDICAL HISTORY (continued)

	ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY			ADDITIONAL COMMENTS
23	**Broken bones?** For any "YES" answers, list date, area affected and treatment:	☐ YES	☐ NO	
	Orthopedic Pins/Plates?	☐ YES	☐ NO	
	Dislocations?	☐ YES	☐ NO	
	Back injuries? For any "YES" answers, list date, area affected and treatment:	☐ YES	☐ NO	
	Chronic Pain? Describe.	☐ YES	☐ NO	
24	**Have you ever been or are you currently treated for?**	☐ YES	☐ NO	
	☐Schizophrenia ☐Depression ☐Bipolar ☐ Panic Attacks ☐Anxiety Attacks ☐Obsessive/Compulsive Disorder ☐Suicide Attempt/Thoughts ☐Eating Disorders ☐Addiction ☐Other:_________________ ☐Post Traumatic Stress Syndrome?			
	Have you ever been hospitalized for psychiatric treatment? Describe with length and dates:	☐ YES	☐ NO	
25	**Do you drink alcohol?**	☐ YES	☐ NO	
	Quantity per day_________ Total per week________			
	Have you ever felt you should decrease your drinking? Explain:	☐ YES	☐ NO	
	Have you ever received a DUI or court ordered treatment? Describe circumstances:	☐ YES	☐ NO	
	Have you ever been diagnosed as an alcoholic?	☐ YES	☐ NO	
	If now sober, length of sobriety_________________			
26	**For Men**:	☐ YES	☐ NO	
	History of Prostate disease including prostatitis or prostate stones?	☐ YES	☐ NO	
	When? Describe treatment:			
	Surgery required?	☐ YES	☐ NO	
	Date______________________			

PERSONAL MEDICAL HISTORY (continued)

27 **For Women**:

Date of last period: ______________________________

Date of last PAP Smear: ________________________

Results: ☐ Normal ☐ Other (describe):

Are you currently taking Oral contraceptives?	☐ YES	☐ NO
History of severe Menstrual Cramps/PMS?	☐ YES	☐ NO
Endometriosis?	☐ YES	☐ NO
Ovarian Cysts?	☐ YES	☐ NO

Describe treatment:

I certify that the information contained herein is complete and accurate to the best of my knowledge. I will inform the contractor's medical staff of ALL medical/health changes that occur after submitting this form. I understand that failure to provide any or all of the requested information may result in a denial of my application for assignment to the Polar Regions. I also understand that willfully providing false statements to a Federal agency or its representatives is a criminal offense.

________________________________ ________________________________ ______________

Print Name | Signature | Date