

DEPARTMENT OF THE INTERIOR
STANDARD MEDICAL HISTORY AND EXAMINATION FORM

***** CAUTION *****

WHEN COMPLETED, THIS DOCUMENT CONTAINS CONFIDENTIAL MEDICAL INFORMATION

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: Please see the Privacy Act Notice on the next page of this form. Prior to your examination appointment, please complete ALL of the shaded portions of the following pages of this form, sign and date it in the spaces provided on pages 5 through 9, 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.

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, 5 CFR 339, and Executive Orders 12107 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--

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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 an 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.

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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.

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: Your Current Occupation: Your Current Employer: Time in Current Position (in years/months): |
| Name of Agency: | | |
| Examinee's Name: | Position/Job Title: | SS# |
| Address: | Work Location: | Region: |
| | Home Phone: | Work Phone: |
| Date of Scheduled Exam: | Date of Birth: | Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> |
| DOI OHS PROGRAM MANAGER | EXAMINING PHYSICIAN (Please Note - Core Exam Must <i>Always</i> be Completed, Plus All Function-Specific Services Shown on Following Page) | |
| TYPE OF EXAMINATION <input type="checkbox"/> Pre-placement/Baseline/Exit <input type="checkbox"/> Periodic SPECIFY FUNCTION AND/OR CLEARANCES REQUESTED (Check ALL That Apply) <input type="checkbox"/> Respirator User [requires completion of the <i>Request for Respirator Clearance</i> form] <input type="checkbox"/> Law Enforcement (Note #1: A different form for LE officers may be required. Contact the Office of Managing Risk and Public 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.) <input type="checkbox"/> Diver <input type="checkbox"/> Wildland Firefighter <input type="checkbox"/> Commercial Drivers License <input type="checkbox"/> Hazardous Waste Worker <input type="checkbox"/> Inspector <input type="checkbox"/> Tower Climber <input type="checkbox"/> Other (specify) | PRE-PLACEMENT/BASELINE/EXIT CORE EXAM Required Services: (Check those services completed) <input type="checkbox"/> Authorization for Disclosure Form <input type="checkbox"/> General Medical History <input type="checkbox"/> General Physical Examination <input type="checkbox"/> Chemistry Panel (including Glucose, Bilirubin (total), Cholesterol, HDL-C, LDL-C, Triglycerides, GGTP, LDH, SGOT, SGPT), Complete Blood Count, and Urinalysis <input type="checkbox"/> Audiometry (including noise exposure history) <input type="checkbox"/> Electrocardiogram <input type="checkbox"/> Spirometry <input type="checkbox"/> Vision Screening (Corrected and Uncorrected Near and Far; Color; Peripheral; Depth Perception) <input type="checkbox"/> Plus other Function or Clearance-required services (see the following page) | PERIODIC CORE EXAM Required Services: (Check those services completed) <input type="checkbox"/> Authorization for Disclosure Form <input type="checkbox"/> General Medical History <input type="checkbox"/> General Physical Examination <input type="checkbox"/> Chemistry Panel (including Glucose, Bilirubin (total), Cholesterol, HDL-C, LDL-C, Triglycerides, GGTP, LDH, SGOT, SGPT), Complete Blood Count, and Urinalysis <input type="checkbox"/> Plus other Function or Clearance-required services (see the following page) 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 DC <i>Request for Respirator Clearance</i> form must precede this exam and be attached to this exam form when completed. |

This examination does not substitute for periodic health evaluations conducted by your personal health care provider. It is being conducted for occupational purposes.

FUNCTION AND CLEARANCE-SPECIFIC EXAMINATION COMPONENTS

Respirator User

- Pre-Placement/Baseline/Exit Core Exam Services, plus:
 - DOI Request for Respirator Clearance form
 - (May be a Limited Exam)
- (Use above for any Respirator User exam)

Law Enforcement

- Pre-Placement/Baseline/Exit Core Exam Services, plus:
 - Tonometry
 - 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)
 - Tonometry (if over age 40 or medically indicated)
 - 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)

Other (specify)

- Pre-Placement/Baseline/Exit Core Exam Services, plus:
 -
- Periodic Core Exam Services, plus:
 -

Diver

- Pre-Placement/Baseline/Exit Core Exam Services, plus:
 - Chest X-Ray (PA/Lat)
 - Stress EKG (Requires MRO Clearance)
 - Blood Type and Rh
 - Sickle Cell Prep
 - Syphilis Serology
- Periodic Core Exam Services, plus:
 - Audiogram (every 5 years) (including noise exposure history)
 - Vision (Cor. and Uncor. Near/Far; Peripheral; Depth)
 - Chest X-Ray (PA/Lat) (every 2 years after age 40)
 - Electrocardiogram (every year after age 35)
 - Syphilis Serology

Wild Land Fire Fighter

- Pre-Placement/Baseline/Exit Core Exam Services, plus:
 - Chest X-ray (PA/Lat)
 - Cholinesterase (RBC/Plasma)
 - Tuberculosis skin test (PPD, Mantoux) – recommended but not required
 - Tetanus booster (if needed) – recommended but not required
- Periodic Core Exam Services, plus:
 - Audiometry (including noise exposure history)
 - Vision (Cor. and Uncor. Near/Far; Color; Periph.; Depth)
 - Spirometry

Commercial Drivers License

- Periodic Core Exam Services, plus:
 - Audiometry (including noise exposure history)
 - Vision (Corr. and Uncorr. Near/Far; Color; Peripheral; Depth)

Hazardous Waste Worker

- 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

Inspector (Offshore or Onshore Inspections)

- 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)

Tower Climber

- Pre-Placement/Baseline/Exit Core Exam Services, plus:
 - 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)

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.)

- A. Have you ever been treated for a mental or emotional condition? (If Yes, specify when, where, and give details.) Yes No
- B. Have you had or have you been advised to have any operation? (If Yes, specify when, and give details.) Yes No
- C. Have you ever been a patient in any type of hospital after infancy? (If Yes, specify when, where, and give details.) Yes No
- 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.) Yes No
- E. Have you ever had any other serious illness/injury? (If yes, specify when, where, and give details.) Yes No
- 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.) Yes No
- 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.) Yes No
- 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.) Yes No

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
(If no, please skip the rest of this section.)

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?

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Persistent cough or shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Unexplained general weakness or fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Asbestosis or silicosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Broken ribs or chest injury |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain on deep inspiration |
| <input type="checkbox"/> | <input type="checkbox"/> | Sensation of smothering when using a respirator |
| <input type="checkbox"/> | <input type="checkbox"/> | Heat exhaustion or heat stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble smelling odors |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty squatting |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty climbing stairs or ladder carrying 25# weight |
| <input type="checkbox"/> | <input type="checkbox"/> | 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.

Describe Your Physical Activity or Exercise Program (check one)

Intensity: Low _____ Moderate _____ High _____ Duration, in Minutes per Session _____

Describe activity _____ Frequency _____ Days per week

Client Signature: _____ Date: _____

| MEDICAL HISTORY | | | | | | DIAGNOSTIC AND PHYSICAL FINDINGS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|----------|--|--------------------------|----------------------------------|------------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|------|--------------------------|--------------------------|-------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|---|---|-----|----|--|--------------------------|--------------------------|---|--------------------------|--------------------------|----------|--------------------------|--------------------------|----------|--------------------------|--------------------------|---------|--------------------------|--------------------------|---|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|---|--------------------------|--------------------------|---|
| <p style="text-align: center;">ENDOCRINE</p> <p>Do you have any endocrine (hormone) disease? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes (insulin requiring; units per day _____)? Yes No (Year of diagnosis _____) <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes (non-insulin requiring)? Yes No (Year of diagnosis _____) <input type="checkbox"/> <input type="checkbox"/></p> <p>Childhood Onset Diabetes? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid Disease? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Obesity? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Unexplained weight loss or gain? Yes No <input type="checkbox"/> <input type="checkbox"/></p> | <p style="text-align: center;">OBSTETRIC</p> <p>Are you currently pregnant? Yes No NA* <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="text-align: right;">*Male; question not applicable</p> | <p>Comments/Findings (Attach copy of blood chemistry panel report.)</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p style="text-align: center;">MENTAL HEALTH</p> <p>Do you have any psychiatric or mental health problems? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>History of psychosis? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Psychiatric/psychological consultation? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Difficulty dealing with stress? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Panic attacks, hyperventilation, or anxiety or phobia disorder? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Periods of uncontrollable rage? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Claustrophobia? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Diagnosed depression, personality disorder, or neuroses? Yes No <input type="checkbox"/> <input type="checkbox"/></p> | <p style="text-align: center;">DERMATOLOGY/ALLERGY</p> <p>Do you have any skin or allergy diseases? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Sun sensitivity? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Allergic dermatitis to rubber or latex? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>History of chronic dermatitis? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Active skin disease or infections? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Moles that have changed in size or color? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Allergies, including hay fever? (if so, to what?) Yes No <input type="checkbox"/> <input type="checkbox"/></p> | <p>Comments/Findings</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p style="text-align: center;">MUSCULOSKELETAL</p> <p>Do you have any muscle or bone disease? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Moderate to severe joint pain, arthritis, tendonitis? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Amputations? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Loss of use of arm, leg, fingers, or toes? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Loss of sensation? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Loss of strength in hands, arms, legs or feet? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Loss of coordination? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Back injury? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Chronic back pain? (back pain associated with neurological deficit or leg pain) Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Are you RIGHT <input type="checkbox"/> or LEFT <input type="checkbox"/> handed? (check one)</p> | <p><u>Musculoskeletal</u></p> <table style="width: 100%;"> <tr> <td style="width: 10%;">Normal</td> <td style="width: 10%;">Abnormal</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Upper extremities (strength)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Upper extremities (range of motion)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Lower extremities (strength)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Lower extremities (range of motion)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Feet</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hands</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Spine, other musculoskeletal</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Flexibility of neck, back, spine, hips, knees</td> </tr> </table> <p>Comments/Findings</p> | Normal | Abnormal | | <input type="checkbox"/> | <input type="checkbox"/> | Upper extremities (strength) | <input type="checkbox"/> | <input type="checkbox"/> | Upper extremities (range of motion) | <input type="checkbox"/> | <input type="checkbox"/> | Lower extremities (strength) | <input type="checkbox"/> | <input type="checkbox"/> | Lower extremities (range of motion) | <input type="checkbox"/> | <input type="checkbox"/> | Feet | <input type="checkbox"/> | <input type="checkbox"/> | Hands | <input type="checkbox"/> | <input type="checkbox"/> | Spine, other musculoskeletal | <input type="checkbox"/> | <input type="checkbox"/> | Flexibility of neck, back, spine, hips, knees | <p>Please assess the following, if box is checked: <input type="checkbox"/></p> <p><u>Medically cleared to perform the following:</u></p> <table style="width: 100%;"> <tr> <td style="width: 10%;">Yes</td> <td style="width: 10%;">No</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Vigorous aerobic exercise program 3 hr/wk</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Push ups</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Pull ups</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Sit ups</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>One and one half mile (1 1/2) timed run</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>3-mile timed walk</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Squat/rise w/o holding on; hold squat 45 sec.</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Kneel on one knee, arms extended for 7 sec.</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Assume a 1 then 2 knee kneeling position w/i 2 seconds, rise w/o assistance, repeat</td> </tr> </table> <p>Comments/Findings</p> | Yes | No | | <input type="checkbox"/> | <input type="checkbox"/> | Vigorous aerobic exercise program 3 hr/wk | <input type="checkbox"/> | <input type="checkbox"/> | Push ups | <input type="checkbox"/> | <input type="checkbox"/> | Pull ups | <input type="checkbox"/> | <input type="checkbox"/> | Sit ups | <input type="checkbox"/> | <input type="checkbox"/> | One and one half mile (1 1/2) timed run | <input type="checkbox"/> | <input type="checkbox"/> | 3-mile timed walk | <input type="checkbox"/> | <input type="checkbox"/> | Squat/rise w/o holding on; hold squat 45 sec. | <input type="checkbox"/> | <input type="checkbox"/> | Kneel on one knee, arms extended for 7 sec. | <input type="checkbox"/> | <input type="checkbox"/> | Assume a 1 then 2 knee kneeling position w/i 2 seconds, rise w/o assistance, repeat |
| Normal | Abnormal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper extremities (strength) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper extremities (range of motion) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Lower extremities (strength) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Lower extremities (range of motion) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Feet | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hands | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Spine, other musculoskeletal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Flexibility of neck, back, spine, hips, knees | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Vigorous aerobic exercise program 3 hr/wk | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Push ups | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Pull ups | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Sit ups | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | One and one half mile (1 1/2) timed run | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 3-mile timed walk | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Squat/rise w/o holding on; hold squat 45 sec. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Kneel on one knee, arms extended for 7 sec. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Assume a 1 then 2 knee kneeling position w/i 2 seconds, rise w/o assistance, repeat | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Client Signature: _____ Date: _____

| MEDICAL HISTORY | | | DIAGNOSTIC AND PHYSICAL FINDINGS | | |
|--|--|--|---|--|--------------------------|
| <p align="center">NEUROLOGICAL</p> <p>Yes No</p> <p>Do you have any neurological disease? <input type="checkbox"/> <input type="checkbox"/></p> <p>Tremors, shakiness? <input type="checkbox"/> <input type="checkbox"/></p> <p>Seizures (recent or previous)? <input type="checkbox"/> <input type="checkbox"/></p> <p>Spinal Cord Injury? <input type="checkbox"/> <input type="checkbox"/></p> <p>Numbness or tingling? <input type="checkbox"/> <input type="checkbox"/></p> <p>Head/spine surgery? <input type="checkbox"/> <input type="checkbox"/></p> <p>History of head trauma with persistent deficits? <input type="checkbox"/> <input type="checkbox"/></p> <p>Chronic recurring headaches (migraine)? <input type="checkbox"/> <input type="checkbox"/></p> <p>Brain tumor? <input type="checkbox"/> <input type="checkbox"/></p> <p>Loss of memory? <input type="checkbox"/> <input type="checkbox"/></p> <p>Insomnia (difficulty sleeping)? <input type="checkbox"/> <input type="checkbox"/></p> | | | <p>Neurological</p> <p>Normal Abnormal</p> <p><input type="checkbox"/> <input type="checkbox"/> Cranial Nerves (I - XII)</p> <p><input type="checkbox"/> <input type="checkbox"/> Cerebellum</p> <p><input type="checkbox"/> <input type="checkbox"/> Motor/Sensory (include vibratory and proprioception)</p> <p><input type="checkbox"/> <input type="checkbox"/> Deep Tendon reflexes</p> <p><input type="checkbox"/> <input type="checkbox"/> Mental Status Exam</p> | | <p>Comments/Findings</p> |
| <p align="center">GASTROINTESTINAL</p> <p>Yes No</p> <p>Do you have any stomach or intestinal disease? <input type="checkbox"/> <input type="checkbox"/></p> <p>Hernias? <input type="checkbox"/> <input type="checkbox"/></p> <p>Colostomy? <input type="checkbox"/> <input type="checkbox"/></p> <p>Persistent stomach/abdominal pain or heartburn? <input type="checkbox"/> <input type="checkbox"/></p> <p>Active ulcer disease? <input type="checkbox"/> <input type="checkbox"/></p> <p>Hepatitis, or other liver disease? <input type="checkbox"/> <input type="checkbox"/></p> <p>Irritable bowel syndrome? <input type="checkbox"/> <input type="checkbox"/></p> <p>Rectal bleeding? <input type="checkbox"/> <input type="checkbox"/></p> <p>Vomiting blood? <input type="checkbox"/> <input type="checkbox"/></p> | | | <p>Gastrointestinal</p> <p>Normal Abnormal</p> <p><input type="checkbox"/> <input type="checkbox"/> Auscultation</p> <p><input type="checkbox"/> <input type="checkbox"/> Palpation</p> <p><input type="checkbox"/> <input type="checkbox"/> Organo-megaly</p> <p><input type="checkbox"/> <input type="checkbox"/> Tenderness</p> <p><input type="checkbox"/> <input type="checkbox"/> Inguinal hernia</p> <p>Attach blood chemistry panel report</p> | | <p>Comments/Findings</p> |
| <p align="center">GENTOURINARY</p> <p>Yes No</p> <p>Do you have any disease of the urinary system or genitals? <input type="checkbox"/> <input type="checkbox"/></p> <p>Blood in urine? <input type="checkbox"/> <input type="checkbox"/></p> <p>Kidney Stones? <input type="checkbox"/> <input type="checkbox"/></p> <p>Difficult or painful urination? <input type="checkbox"/> <input type="checkbox"/></p> <p>Infertility (difficulty having children)? <input type="checkbox"/> <input type="checkbox"/></p> | | | <p>Genitourinary</p> <p>Normal Abnormal</p> <p><input type="checkbox"/> <input type="checkbox"/> Urogenital exam</p> <p>(Attach urinalysis report, if done.)</p> | | <p>Comments/Findings</p> |

Client Signature: _____ Date: _____

MEDICAL HISTORY

VISION

| | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| Do you have any vision problems or eye disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| Blurred vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of vision in either eye? | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye irritation when using a respirator or goggles? | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty reading? | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye disease, glaucoma? | <input type="checkbox"/> | <input type="checkbox"/> |
| Eyeglasses? | <input type="checkbox"/> | <input type="checkbox"/> |
| Contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| Cataracts? | <input type="checkbox"/> | <input type="checkbox"/> |
| Color blindness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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: | <input type="checkbox"/> | <input type="checkbox"/> |

HEARING

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

DIAGNOSTIC AND PHYSICAL FINDINGS

Head and Neck

| | |
|--------------------------|--|
| Normal | Abnormal |
| <input type="checkbox"/> | <input type="checkbox"/> Head, Face, Neck (thyroid), Scalp |
| <input type="checkbox"/> | <input type="checkbox"/> Nose/Sinuses/Eustachian tube |
| <input type="checkbox"/> | <input type="checkbox"/> Mouth/Throat |
| <input type="checkbox"/> | <input type="checkbox"/> Pupils equal/reactive |
| <input type="checkbox"/> | <input type="checkbox"/> Ocular Motility |
| <input type="checkbox"/> | <input type="checkbox"/> Ophthalmoscopic Findings |
| <input type="checkbox"/> | <input type="checkbox"/> Speech |

Comments/Findings

Eyes / Vision

Color Vision
 Normal Abnormal Number Correct: _____ of _____ tested
 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 Perception (Type of test: _____)
 Normal Abnormal Number Correct: _____ of _____ tested
 Interpretation: _____ Seconds of Arc

Ears

| | | |
|--------------------------|--------------------------|---|
| Right | Normal | Abnormal |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Canal/External ear |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Tympanic Membrane |
| Left | Normal | Abnormal |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Canal/External ear |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Tympanic Membrane |

Comments/Findings:

Hearing

Audiogram: Type: Baseline Annual Termination
 (Attach current and baseline audiogram)

With hearing aid? Yes No
 (Note: The use of hearing aids is not acceptable for some clearance examinations, such as for law enforcement.)

Calibration Method: Oscar Biological Date _____

| 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:

Client Signature: _____ Date: _____

| PROFESSIONAL STAFF Please check all the topics you discussed during the diagnostic work-up or physical examination | EXAMINING PHYSICIAN: WORKPLACE EXPOSURE MONITORING | EXAMINING PHYSICIAN Summary of Abnormal Findings with Plan of Action/Referral |
|--|--|---|
| <input type="checkbox"/> Diet <input type="checkbox"/> Low-calorie <input type="checkbox"/> Low-fat <input type="checkbox"/> Low-salt <input type="checkbox"/> Cholesterol <input type="checkbox"/> Hypertension <input type="checkbox"/> Exercise <input type="checkbox"/> Obesity <input type="checkbox"/> Smoking Cessation <input type="checkbox"/> Avoid Sun Exposure/Sun Screen <input type="checkbox"/> Alcohol Use <input type="checkbox"/> Cancer Screening <input type="checkbox"/> Immunizations <input type="checkbox"/> Hearing Protection <input type="checkbox"/> Vision Referral <input type="checkbox"/> Other Personal Protective Equipment <input type="checkbox"/> Job Stressors <input type="checkbox"/> Referral(s) Others _____ | <p>Is workplace monitoring data or other exposure data for this employee or this position available for your review? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what type of data is available? <input type="checkbox"/> Acute Exposure Data <input type="checkbox"/> Periodic Exposure Data <input type="checkbox"/> Ongoing Workplace Monitoring Data <input type="checkbox"/> Individual Dosimetry Data <input type="checkbox"/> Material Safety Data Sheets</p> <p>How was data made available? <input type="checkbox"/> Electronic Database <input type="checkbox"/> Hard Copy Report <input type="checkbox"/> Employee Self-Report</p> <p>If exposure data was available, please explain what changes, if any, were made in the examination due to this data: _____ _____</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cannot determine based on information available <input type="checkbox"/> Other _____</p> | <p>Impressions: _____</p> <p>1) _____</p> <p>_____</p> <p>2) _____</p> <p>_____</p> <p>3) _____</p> <p>_____</p> <p>4) _____</p> <p>_____</p> <p>5) _____</p> <p>_____</p> <p>Plan: _____</p> <p>1) _____</p> <p>_____</p> <p>2) _____</p> <p>_____</p> <p>3) _____</p> <p>_____</p> <p>4) _____</p> <p>_____</p> <p>5) _____</p> <p>_____</p> <p>_____</p> |

SIGNATURES _____ DATE _____

Nurse _____

Physician _____

I have had the examination findings explained to me and received a copy of the examination if requested. I understand the recommendations.

Client _____

PLEASE BE SURE ALL REQUIRED SECTIONS OF THIS FORM HAVE BEEN COMPLETED AND ARE LEGIBLE BEFORE RETURNING IT FOR REVIEW BY THE DESIGNATED MEDICAL REVIEW OFFICER. THANK YOU.

DEPARTMENT OF THE INTERIOR
OCCUPATIONAL HEALTH SERVICES PROGRAM

Medical Review Officer's Qualification Statement

Name of Examined Individual: _____
SS#: _____

Physician/Clinic Address: _____

Date of Birth: _____

Physician/Clinic Phone: _____

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

| <u>Functional Clearance Area</u> | <u>Pre-placement / Baseline / Exit</u> | <u>Periodic</u> | <u>Functional Clearance Area</u> | <u>Pre-placement / Baseline / Exit</u> | <u>Periodic</u> |
|----------------------------------|--|--------------------------|----------------------------------|--|--------------------------|
| Respirator Use | <input type="checkbox"/> | <input type="checkbox"/> | Hazardous Waste Work | <input type="checkbox"/> | <input type="checkbox"/> |
| Law Enforcement | <input type="checkbox"/> | <input type="checkbox"/> | Inspector | <input type="checkbox"/> | <input type="checkbox"/> |
| Diver | <input type="checkbox"/> | <input type="checkbox"/> | Tower Climber | <input type="checkbox"/> | <input type="checkbox"/> |
| Wildland Firefighter | <input type="checkbox"/> | <input type="checkbox"/> | Other (specify: _____) | <input type="checkbox"/> | <input type="checkbox"/> |
| Commercial Driver's License | <input type="checkbox"/> | <input type="checkbox"/> | Other (specify: _____) | <input type="checkbox"/> | <input type="checkbox"/> |

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: _____