

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
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

List Any Dietary Restrictions: 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

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:

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)

Page ____ of ____

NOAA Health Services Questionnaire Continuation Page

Name: _____