

MEDICAL HISTORY

Complete pages 1-5 in ink prior to Dr.'s exam	Polar Medical Staff Use Only Date: _____ <input type="checkbox"/> PQ <input type="checkbox"/> PQ Summer Only <input type="checkbox"/> NPQ
Polar Medical Staff Use Only Reviewed by: _____ Date: _____	Medical Condition(s): <hr/> Restrictions and Follow-up: <hr/> <hr/> Reason for NPQ: <hr/> <hr/>

Name: last, first, middle (must match passport)	Age: _____	Birth date (YY/MM/DD): _____	Sex <input type="checkbox"/> F <input type="checkbox"/> M
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Nickname (aka)	Maiden Name	Previous Name or Other Legal Name:
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Street	City	State	Zip
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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: _____
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Affiliation: <input type="checkbox"/> NSF <input type="checkbox"/> Science Event # _____ <input type="checkbox"/> Technical Event # _____ <input type="checkbox"/> RPSC <input type="checkbox"/> VECO <input type="checkbox"/> Other: _____	Proposed Antarctic Season and Worksite: <input type="checkbox"/> Summer (Sep-Feb) <input type="checkbox"/> Winter (Mar-Oct) <input type="checkbox"/> Winfly _____ (dates) <input type="checkbox"/> McMurdo Station <input type="checkbox"/> South Pole Station <input type="checkbox"/> Palmer Station <input type="checkbox"/> RV/NB Palmer <input type="checkbox"/> RV/LM Gould <input type="checkbox"/> Field Camp _____ <input type="checkbox"/> Other: _____	Proposed Arctic Season and Worksite: <input type="checkbox"/> Summer (Mar-Sep) <input type="checkbox"/> Winter (Oct-Feb) <input type="checkbox"/> Summit <input type="checkbox"/> Alaska _____ <input type="checkbox"/> USCGC Healy <input type="checkbox"/> Field Camp _____ <input type="checkbox"/> Other: _____
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NAME _____ DOB _____

PERSONAL MEDICAL HISTORY (continued)

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

<p>1 Neurological Disorder?</p> <p>a. Multiple Sclerosis <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>b. Fibromyalgia <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>c. Other Nerve/Muscle Disorders? (Describe.) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>_____</p> <p>d. Seizure disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO Date of Last Seizure: _____</p> <p>e. Head Injury? <input type="checkbox"/> YES <input type="checkbox"/> NO Loss of Consciousness – Date _____ How Long _____</p>	
<p>2 Headaches? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Migraines ? <input type="checkbox"/> YES <input type="checkbox"/> NO Date Diagnosed _____ Date of last Migraine _____</p>	
<p>3/8 Do you have diabetes? <input type="checkbox"/> YES <input type="checkbox"/> NO Date diagnosed: _____ Controlled by: <input type="checkbox"/> Insulin <input type="checkbox"/> Oral medication <input type="checkbox"/> Diet Last Emergency Room visit: _____</p>	
<p>4/9 Do you have Cholesterol disorders? <input type="checkbox"/> YES <input type="checkbox"/> NO Date diagnosed: _____ Controlled by: <input type="checkbox"/> Oral medication <input type="checkbox"/> Diet</p>	
<p>5/1 Do you have Thyroid Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO 2 Explain, if Yes - include medication</p> <p>Surgery required? <input type="checkbox"/> YES <input type="checkbox"/> NO When? _____</p>	

PERSONAL MEDICAL HISTORY (continued)

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY	ADDITIONAL COMMENTS
<p>6/3 Vision: Do you wear glasses? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">contacts? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have unequal pupils? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have blindness in one or both eyes? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have Glaucoma? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have Cataracts <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have Double Vision? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you have other vision problems? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Describe:</p>	
<p>7/4 Dizziness/Fainting <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Reason:</p> <p style="padding-left: 40px;">Date of occurrence: _____</p>	
<p>8/5 Do you have ear, nose, or throat problems? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Describe:</p> <p style="padding-left: 40px;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Hearing Impairment? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Hayfever? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Are you currently taking allergy shots?</p>	
<p>9/6 Do you have any Pulmonary Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Chronic Obstructive Pulmonary Disease (COPD)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Pulmonary Embolism/Blood Clots? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Sleep Apnea? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Asthma? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 80px;">Date of last attack _____</p> <p style="padding-left: 80px;">Number of attacks in past year _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Hospitalizations? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Nebulizer treatment in the past year? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">How often? _____</p> <p style="padding-left: 40px;">Emphysema or chronic Bronchitis or Bronchiectasis? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 40px;">Shortness of Breath or Difficult Breathing? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 80px;">Explain:</p> <p style="padding-left: 40px;">Tuberculosis <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 80px;">History of positive TB skin test</p> <p style="padding-left: 80px;">Have you ever received BCG?</p> <p style="padding-left: 40px;">Have you ever experienced altitude sickness? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 80px;">At what altitude _____</p> <p style="padding-left: 40px;">Describe treatment:</p>	

PERSONAL MEDICAL HISTORY (continued)

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY		ADDITIONAL COMMENTS
10/7	<p>Do you have Heart Problems/Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Previous Heart Attack? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Angina/Chest Pain? <input type="checkbox"/> YES <input type="checkbox"/> NO Describe (include frequency, precipitating factors, and treatments): _____ _____ _____</p> <p>Congestive Heart Failure (CHF)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Supraventricular Tachycardia (SVT)? <input type="checkbox"/> YES <input type="checkbox"/> NO Date diagnosed _____ Frequency and treatment: _____ _____</p> <p>Atrial Fibrillation? <input type="checkbox"/> YES <input type="checkbox"/> NO Date diagnosed _____</p> <p>Heart Murmur/Valvular Heart Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO Date diagnosed _____ Limitations: _____</p> <p><input type="checkbox"/> Angiogram <input type="checkbox"/> Angioplasty <input type="checkbox"/> Stent <input type="checkbox"/> Cardiac Bypass Surgery Date _____</p> <p>Pacemaker? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Hypertension? <input type="checkbox"/> YES <input type="checkbox"/> NO Date diagnosed _____</p> <p>TIA/Stroke? <input type="checkbox"/> YES <input type="checkbox"/> NO Date _____</p> <p>History of Deep Vein Thrombosis (DVT)/Blood Clots? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>History of Abdominal or Cerebral Aneurysm? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
11/10	<p>Arthritis? <input type="checkbox"/> YES <input type="checkbox"/> NO Type: _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Permanent disability? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
12/11	<p>Do you have Gout? <input type="checkbox"/> YES <input type="checkbox"/> NO If so, describe your treatment plan _____</p>	
13	<p>Have you ever used tobacco/tobacco products? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you currently use tobacco/tobacco products? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Type of use <input type="checkbox"/> cigarettes <input type="checkbox"/> cigar <input type="checkbox"/> pipe <input type="checkbox"/> chew</p> <p>Packs per week? _____</p> <p>If you've quit, last year of use _____</p> <p>Number of years of tobacco use in past _____</p>	

PERSONAL MEDICAL HISTORY (continued)

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

PERSONAL MEDICAL HISTORY (continued)

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

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