NATIONAL SCIENCE FOUNDATION - POLAR PHYSICAL EXAMINATION

MEDICAL HISTORY

Complete pages 1-5 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:

Polar Medical Staff Use Only

Reviewed by:_____

Date: _____

Reason for NPQ:

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:_____

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 of: Check box, If yes, who? (Explain.):			Relationship	**Family History of**: Check box, If yes, who? (Explain.):			Relationship
Diabetes? Insulin Required?	☐ YES ☐ YES	☐ NO ☐ NO		Kidney Disease? Describe:	☐ YES	☐ NO	
Heart Attack? Age? _____	☐ YES	☐ NO		Cancer? Type? Treatment?	☐ YES	☐ NO	
Stroke? Age? _____	☐ YES	☐ NO					
Bleeding Disorder? Describe: (Hemophilia, Clotting Factor Deficiency) _____	☐ YES	☐ NO		Stomach/GI Disease? Type? _____ _____	☐ YES	☐ NO	
Autoimmune Disorder? Describe: (Rheumatoid Arthritis, Lupus, Other) _____	☐ YES	☐ NO		Mental Health Disorders? Describe: (i.e., Depression, Bipolar, Suicide, Schizophrenia) _____	☐ YES	☐ NO	
Hemoglobin disorder? Describe: (Sickle Cell, Thalassemia, etc.)	☐ YES	☐ NO					

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?

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**
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	
3/8	**Do you have diabetes**? Date diagnosed:_____ Controlled by: ☐Insulin ☐Oral medication ☐Diet Last Emergency Room visit:_____	☐ YES ☐ NO	
4/9	**Do you have Cholesterol disorders?** **Date diagnosed:**_____ **Controlled by: ☐Oral medication ☐Diet**	☐ YES ☐ NO	
5/1 2	**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
6/3	**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	
7/4	**Dizziness/Fainting** Reason: Date of occurrence:_____	☐ YES ☐ NO	
8/5	**Do you have ear, nose, or throat problems?** Describe:	☐ YES ☐ NO	
	Hearing Impairment?	☐ YES ☐ NO	
	Hayfever?	☐ YES ☐ NO	
	Are you currently taking allergy shots?	☐ YES ☐ NO	
9/6	**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? Nebulizer treatment in the past year?	☐ YES ☐ NO	
	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
10/7	**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	
11/10	**Arthritis?**	☐ YES	☐ NO	
	Type: _____ Permanent disability?	☐ YES	☐ NO	
12/11	**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 _____			

NAME_____ DOB _____

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**_____	☐ YES ☐ NO	
	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?		
	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_____		

NAME_____ DOB _____

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