

**POLAR PHYSICAL EXAMINATION**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**BLOOD TYPE:** \_\_\_\_\_

COMPLETE ALL SECTIONS USING CODES WHERE APPROPRIATE

VITAL SIGNS		VISION			
		WITHOUT CORRECTION		WITH CORRECTION	
HEIGHT: _____	WEIGHT: _____	DIST	NEAR	DIST	NEAR
BP: _____/_____	HEART RATE: _____	R _____	_____	R _____	_____
RESPIRATIONS: _____	TEMPERATURE: _____	L _____	_____	L _____	_____

CODES: O – Within Limits  
 I – Significantly Abnormal  
 X – Not Examined

Code      Remarks (discuss abnormal findings in detail)

1. General Appearance.....		
2. Head and neck.....		
3. Eyes.....		
4. Ears.....		
5. Nose.....		
6. Mouth.....		
7. Thyroid.....		
8. Lymph nodes.....		
9. Chest, Lungs, Breasts.....		
10. Heart.....		
11. Abdomen.....		
12. Inguinal, include hernia.....		
13. Genitalia.....		
14. Anal and Rectum.....		
15. Spine.....		
Forward Bend, Fingers Miss Floor ____ Inches		
16. Upper Extremities.....		
17. Lower Extremities.....		
Varicosities.....		
18. Skin, Lymphadenopathy.....		
Identify Body Marks, Scars, Tattoos.....		
19. Peripheral Vascular.....		
20. Neurologic Status (include Reflexes)....		
21. Emotional Status.....		
22. Pelvic Exam.....		
23. Men > Age 40: Prostate Exam.....		

**Physical Examination**

Guiac Test (Required annually for age 50 and up)	Tetanus Immunization Date (Update every 10 years)	TB Skin Test (Required Annually)
_____ Results                      Date	_____ Date	_____ Results                      Date

**Examiner's Diagnoses and Comments:**

(Please ask the candidate if there is any other medical information not already obtained which should be known prior to deployment.)

I have thoroughly examined this candidate for travel to the Polar Regions. I have reviewed the participant's history with him/her, including ALL positive responses, and commented appropriately. I have performed all diagnostic tests as requested.

\_\_\_\_\_  
 Examiner's Name (Type or Print):

\_\_\_\_\_  
 Examiner's Signature                      DATE

\_\_\_\_\_  
 ADDRESS

\_\_\_\_\_  
 CITY                      STATE                      ZIP

I have been informed regarding the medical examination findings herein (signature optional).

PHONE #: \_\_\_\_\_

\_\_\_\_\_  
 PATIENT'S SIGNATURE                      DATE

Return the completed examination form and results of the requested tests to (return envelope enclosed):

National Science Foundation  
 Attention: **NSF Medical Director**  
 4201 Wilson Boulevard, Ste 265-S  
 Arlington, VA 22230  
 703-292-8124 Fax: 703-292-9001