Transportation Security Administration

TRANSPORTATION SECURITY OFFICER MEDICAL QUESTIONNAIRE

PRIVACY ACT AND PAPERWORK REDUCTION ACT STATEMENTS

The Transportation Security Administration (TSA) requires physical/medical examinations prior to an individual's appointment to a TSA Security Officer (Screener) position. TSA uses the following medical documents to obtain information relevant to an applicant's health status for purposes of making an employment decision. This is a mandatory collection of information if you wish to be considered for a TSA Security Officer (Screener) position. It is estimated that the total average burden per response associated with this collection is approximately 18 minutes. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The control number assigned to this collection is OMB 1652-0032, which expires 09/08.

Failure to submit to the examination or failure to make full and open disclosure of any current or past medical conditions, including incomplete, misleading or inaccurate information, may be grounds for disqualification from TSA employment, or disciplinary or adverse action if employed.

49 U.S.C. § 114 (e) authorizes the collection of this information. TSA will not disclose this information other than for routine uses as identified in OPM system of records, OPM/GOVT-10 if hired, or OPM/GOVT-5 if not hired. Upon written authorization from the individual, the agency may release a copy of the medical record. The individual should forward a notarized letter to the agency identifying to whom the information may be released. Disclosure of your SSN is voluntary. This information is used to identify and separate individuals with similar or identical names or initials. If you do not provide your SSN or any other information requested, we cannot process your application.

INSTRUCTIONS

It is required that you complete each question or response in this questionnaire. After completing each page record your initials in the space provided at the bottom of each page. Your responses will be reviewed with you by a medical professional.

DEMOGRAPHIC INFORMATION

Name (Print): _____

Address: _____

_____

Home Phone #: (__ __ __) __ __ __ - __ __ __ __

Work Phone #: (__ __ __) __ __ __ - __ __ __ __

Other Phone #: (__ __ __) __ __ __ - __ __ __ __

Best Time to Call: _____

Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Sex: **Male** _____ **Female** _____

Date of Birth: _____/_____/_____
(mm / dd / yyyy)

Height: _____**Feet** _____**Inches**

Weight: _____**lbs**

GENERAL INFORMATION

1. Have you been refused employment, dismissed from a job, or unable to stay in school due to any medical condition or excessive absenteeism? 1. **Yes**_____ **No**_____

   If yes, please list each medical condition and record the year of the refusa:

   _____

   _____

2. Have you ever been diagnosed or treated for a mental health condition? 2. **Yes**_____ **No**_____

   If yes , specify the year for each mental health condition and provide details:

   _____

   _____

3. Have you had, or have you been advised to have, any operations? 3. **Yes**_____ **No**_____

   If yes , describe what type of operation and indicate date if appropriate

   _____

   _____

4. Have you been treated at any type of hospital in the last 10 years? 4. **Yes**_____ **No**_____

   If yes , specify when and reason for treatment:

   _____

   _____

5. Have you ever had any illness, injury, or condition (including learning disability, attention deficit disorder, etc.) other than those already noted above? 5. **Yes**_____ **No**_____ **Don't Know** _____

   If yes , specify medical condition and when you were treated

   _____

   _____

GENERAL INFORMATION (continued)

6. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past year for anything other than minor illnesses? 6. **Yes**_____ **No**_____
   If yes, provide an explanation and the name of doctor consulted and/or the hospital/clinic

7. Have you ever been rejected for military service or law enforcement position(s) because of physical, mental, or other medical reasons? 7. **Yes**_____ **No**_____
   If yes, give date and reason for rejection:

8. Have you ever been discharged from military service or a law enforcement position because of physical, mental, or other reasons? 8. **Yes**_____ **No**_____
   If yes, give date and reason. If military discharge, list type (e.g., honorable, other than honorable, for unfitness, unsuitability):

9. Have you ever received a pension or compensation for a disability or work related injury or illness? 9. **Yes**_____ **No**_____
   If yes, complete the chart below for each occurrence:

Disability	Year Disability Granted	Disability related to which body system? Check one.		% Disability Granted		Duration of Disability (Years/Months)	Is disability permanent? (Yes/No)
1		Musculoskeletal					
		Mental Health					
		Other					
2		Musculoskeletal					
		Mental Health					
		Other					
3		Musculoskeletal					
		Mental Health					
		Other					

10. Do you have a valid driver's license? 10. **Yes**_____ **No**_____

11. Are you taking any prescription medications? 11. **Yes**_____ **No**_____
    If yes, list all current prescription medications and check the box that best describes how often you take each medication

Name of Medication	Daily		Weekly	Monthly or Less

VISION:

1. Do you have a total loss of vision in your right eye? 1. **Yes**_____ **No**_____

2. Do you have a total loss of vision in your left eye? 2. **Yes**_____ **No**_____

3. Have you had any type of eye surgery (such as Lasik, cataracts, etc.) in the past year? 3. **Yes**_____ **No**_____

MEDICAL HISTORY

HEARING:

1. Do you have a total loss of hearing in your right ear? — **Yes**_____ **No**_____ **Don't Know** _____
2. Do you have a total loss of hearing in your left ear? — **Yes**_____ **No**_____ **Don't Know** _____
3. Do you wear hearing aids? — **Yes**_____ **No**_____
   If yes, is it a CROS style hearing aid? — ***Yes***_____ ***No***_____ ***Don't Know*** _____

CARDIOVASCULAR: ***Have you EVER had or experienced any of the following?***

1. Chest pains — **Yes**_____ **No**_____
   If yes, has your doctor prescribed heart medication for this? — ***Yes***_____ ***No***_____ ***Don't Know*** _____
2. Palpitations (rapid or skipped heart beat) — **Yes**_____ **No**_____ **Don't Know** _____
   If yes, are you receiving treatment? — ***Yes***_____ ***No***_____ ***Don't Know*** _____
3. Heart murmur — **Yes**_____ **No**_____ **Don't Know** _____
   If yes, has anyone ever recommended heart valve replacement? — ***Yes***_____ ***No***_____ ***Don't Know*** _____
4. Heart valve replacement — **Yes**_____ **No**_____
5. Past history or diagnosis of heart disease — **Yes**_____ **No**_____
6. Coronary bypass surgery or other heart surgery — **Yes**_____ **No**_____
7. Heart attack or stroke — **Yes**_____ **No**_____
8. Abnormal EKG or stress test result — **Yes**_____ **No**_____
9. Pacemaker or implanted defibrillator — **Yes**_____ **No**_____
   a. Pacemaker? — ***Yes***_____ ***No***_____
   b. Implanted defibrillator? — ***Yes***_____ ***No***_____
10. High blood pressure — **Yes**_____ **No**_____ **Don't Know** _____
11. Circulatory problems (e.g., Raynaud's disease, swelling of ankles, leg pains, numbness in feet or hands) — **Yes**_____ **No**_____ **Don't Know** _____
12. Cramps in legs — **Yes**_____ **No**_____
13. Phlebitis or blood clots — **Yes**_____ **No**_____ **Don't Know** _____

RESPIRATORY: ***Have you EVER had or experienced any of the following?***

1. Problems breathing, wheezing, persistent cough or shortness of breath — **Yes**_____ **No**_____
   If yes, how long ago? _____
2. Bronchitis — **Yes**_____ **No**_____ **Don't Know** _____
   If yes, how long ago? _____
3. Blood in sputum or when coughing — **Yes**_____ **No**_____ **Don't Know** _____
   If yes, how long ago? _____
4. Past history or diagnosis of lung disease — **Yes**_____ **No**_____
   If yes, how long ago? _____
5. History of tuberculosis — **Yes**_____ **No**_____
   If yes, how long ago? _____
6. Positive TB test — **Yes**_____ **No**_____
   If yes, how long ago? _____
7. Asthma — **Yes**_____ **No**_____ **Don't Know** _____
   If yes, how long ago? _____

GASTROINTESTINAL: ***Have you EVER had or experienced any of the following?***

1. Persistent stomach or abdominal pain — **Yes**_____ **No**_____
   If yes, how long ago? _____
2. Persistent diarrhea or constipation — **Yes**_____ **No**_____
   If yes, how long ago? _____
3. Blood in stool — **Yes**_____ **No**_____ **Don't Know** _____
   If yes, how long ago? _____

HEPATIC: ***Have you EVER had or experienced any of the following?***

1. Liver disease, jaundice or history of cirrhosis — **Yes**_____ **No**_____ **Don't Know** _____
   If yes, how long ago? _____
2. Hepatitis — **Yes**_____ **No**_____ **Don't Know** _____
   If yes, how long ago? _____

MEDICAL HISTORY (continued)

MUSCULOSKELETAL / ORTHOPEDIC: ***Have you <u>EVER</u> had or experienced any of the following?***

1. Amputated hand or missing hand — **Yes**_____ **No**_____
2. Any other amputation (e.g., leg, finger, toe) — **Yes**_____ **No**_____
3. Back pain — **Yes**_____ **No**_____
   a. *How often do you experience it?* — ***Frequently*** ____ ***Occasionally*** ____
   b. *How often do you take medication for your pain?* — ***Frequently*** ____ ***Occasionally*** ____ ***Never*** ____
4. Back surgery — **Yes**_____ **No**_____
5. Back injury — **Yes**_____ **No**_____
6. Joint pain or swelling — **Yes**_____ **No**_____
7. Loss of joint or limb movement — **Yes**_____ **No**_____
8. Loss of strength or muscle weakness — **Yes**_____ **No**_____
9. Difficulty walking — **Yes**_____ **No**_____
10. Difficultly bending, stooping or squatting — **Yes**_____ **No**_____
11. Difficulty reaching overhead, moving arms in all directions at shoulders — **Yes**_____ **No**_____
12. Arthritis, rheumatism, bursitis or gout — **Yes**_____ **No**_____ **Don't Know** _____
13. Bone, joint, or other deformity — **Yes**_____ **No**_____
14. Foot problems (aching, pain when walking in bare feet) — **Yes**_____ **No**_____
15. Any orthopedic surgery within the past two years — **Yes**_____ **No**_____
16. Any neck (cervical spine) surgery — **Yes**_____ **No**_____
17. Any neck (cervical spine) problems or disorder — **Yes**_____ **No**_____
18. Any fracture(s) with symptoms and/or abnormal range of motion — **Yes**_____ **No**_____ **Don't Know** _____
19. Plate, pin, or rod in any bone — **Yes**_____ **No**_____
20. Check the statement below that best describes how long you can sit continuously without standing or walking:
    I am physically able to sit continuously without taking a break for a total of:
    _____ Less than 1 hour in an 8-hour workday
    _____ At least 1 to 2 hours in an 8-hour workday
    _____ At least 3 to 4 hours in an 8-hour workday
    _____ At least 5 to 6 hours in an 8-hour workday
21. Check the statement below that best describes how long you can stand and walk continuously without sitting or leaning against a table or wall:
    I am physically able to stand and walk continuously without taking a break for a total of:
    _____ Less than 1 hour in an 8-hour workday
    _____ At least 1 to 2 hours in an 8-hour workday
    _____ At least 3 to 4 hours in an 8-hour workday
    _____ At least 5 to 6 hours in an 8-hour workday
22. Do you have any lifting restrictions? — **Yes**_____ **No**_____
    If yes, what is the maximum weight you are allowed to lift? _____ **pounds**
23. Place a check next to the response that best describe how often you lift and/or carry objects for each weight category:

Lift and/or carry (including upward pulling) a maximum of:

Weight	Never / Rarely 0 to 2 times per year	Occasionally 1 to 2 times per month		Frequently Once per week or more
30 pounds	Never or Rarely_____	Occasionally _____		Frequently _____
50 pounds	Never or Rarely_____	Occasionally _____		Frequently _____
70 pounds	Never or Rarely_____	Occasionally _____		Frequently

24. ***<u>How often</u> do you participate in each of the following activities?***

Weight	Never / Rarely 0 to 2 times per year	Occasionally 1 to 2 times per month		Frequently Once per week or more
Climb (Stairs)	Never or Rarely_____	Occasionally _____		Frequently _____
Stoop/Bend/Squat	Never or Rarely_____	Occasionally _____		Frequently _____
Kneel	Never or Rarely_____	Occasionally _____		Frequently

25. **If you have a limitation performing any of the tasks listed below, place a check in the box (right, left) that corresponds to the side of your body with the limitation. Otherwise, check "No Limitations".**

	Limitations		No Limitations
	Right	Left	
a. Can handle or pick up objects from a table with fingers			
b. Can feel objects with fingers and hands (sensation)			
c. Can touch finger tips to palm to make a fist			
d. Can bend elbow and touch fingers to shoulder			

MEDICAL HISTORY (continued)

ENDOCRINE: ***Have you EVER had or experienced any of the following?***

1. Diabetes — **Yes**_____ **No**_____ **Don't Know** _____
2. Thyroid disease — **Yes**_____ **No**_____ **Don't Know** _____
3. Anemia — **Yes**_____ **No**_____ **Don't Know** _____
4. Blood disorder — **Yes**_____ **No**_____ **Don't Know** _____

NEUROLOGICAL: ***Have you EVER had or experienced any of the following?***

1. Localized weakness, numbness, tingling, or loss of sensation in hands, legs, or feet — **Yes**_____ **No**_____ ***If yes***, how long ago? _____
2. Seizures — **Yes**_____ **No**_____ **Don't Know** _____ ***If yes***, how long ago? _____
3. Tremors or shakiness — **Yes**_____ **No**_____ **Don't Know** _____ ***If yes***, how long ago? _____
4. Fainting or dizziness — **Yes**_____ **No**_____ ***If yes***, how long ago? _____
5. Head injury — **Yes**_____ **No**_____ **Don't Know** _____ ***If yes***, how long ago? _____
6. Wear a brace or back support — **Yes**_____ **No**_____ ***If yes***, how long ago? _____
7. Frequent or severe headaches — **Yes**_____ **No**_____ ***If yes***, how long ago? _____
8. Nerve injury — **Yes**_____ **No**_____ **Don't Know** _____ ***If yes***, how long ago? _____
9. Paralysis — **Yes**_____ **No**_____ ***If yes***, how long ago? _____

PSYCHOLOGICAL: ***Have you EVER had or experienced any of the following?***

1. Counseling or psychiatric consultation — **Yes**_____ **No**_____ ***If yes***, how long ago? _____
2. Episodes of depression — **Yes**_____ **No**_____ **Don't Know** _____ ***If yes***, how long ago? _____
3. Periods of nervousness or anxiety — **Yes**_____ **No**_____ **Don't Know** _____ ***If yes***, how long ago? _____
4. Prescribed medication for a mental health condition — **Yes**_____ **No**_____ **Don't Know** _____ ***If yes***, how long ago? _____
5. History of alcoholism or alcohol use — **Yes**_____ **No**_____ **Don't Know** _____ ***If yes***, how long ago? _____
6. History of substance or drug use — **Yes**_____ **No**_____ **Don't Know** _____ ***If yes***, how long ago? _____
7. Suicide attempt or plans — **Yes**_____ **No**_____ ***If yes***, how long ago? _____

GENERAL HISTORY

Answer the following questions:

1. Have you had an organ transplant? — **Yes**_____ **No**_____
2. Are you currently using, or have you in the past used, any narcotic medication or other prescription painkiller? — **Yes**_____ **No**_____
3. Are you currently using, or have you in the past used, sedating medication or tranquilizers? — **Yes**_____ **No**_____ **Don't Know** _____
4. Do you currently have or in the past had a hernia? — **Yes**_____ **No**_____ **Don't Know** _____
   a. *Has it been surgically repaired?* — ***Yes***_____ ***No***_____
   b. *Date of repair?* _____
5. Do you have any skin problems/disease (e.g., urticaria, eczema, dermatitis, psoriasis)? — **Yes**_____ **No**_____ **Don't Know** _____
6. Do you currently have or in the past had cancer? — **Yes**_____ **No**_____
   a. *Type of cancer?* _____
   b. *Date of diagnosis?* _____
   c. *Date of last treatment?* _____
7. Do you have narcolepsy or a sleep disorder? — **Yes**_____ **No**_____ **Don't Know** _____
8. Do you use tobacco? — **Yes**_____ **No**_____

Candidate Initials _____

GENERAL HISTORY (continued)

9. Check the statement below that best describes your ability to lift and carry:

I affirm that I am physically able to pick up and carry a distance of 25 feet (for example, the distance to cross a two-lane street):

_____ 30 lbs. (for example, 2 cases of 12oz. soft drinks -- 24 cans in each case)
_____ 50 lbs. (for example, 3 cases of 12oz. soft drinks -- 24 cans in each case)
_____ 70 lbs. (for example, 4 cases of 12oz. soft drinks -- 24 cans in each case)

10. **What is your present activity level?**

Check the level of activity listed below that best describes how often you participate in each of the activities:

Activity	**Never/Rarely** 0 to 2 times per year	**Occasionally** 1 to 2 times per month	**Frequently** Once per week or more
Walk 2 miles continuously	Never/Rarely_____	Occasionally _____	Frequently _____
Run 2 miles continuously	Never/Rarely_____	Occasionally _____	Frequently _____
Weight training	Never/Rarely_____	Occasionally _____	Frequently _____
General fitness activities at gym	Never/Rarely_____	Occasionally _____	Frequently _____
Basketball	Never/Rarely_____	Occasionally _____	Frequently _____
Tennis, racquetball, badminton	Never/Rarely_____	Occasionally _____	Frequently _____
Soccer	Never/Rarely_____	Occasionally _____	Frequently _____
Gardening	Never/Rarely_____	Occasionally _____	Frequently _____
Golf	Never/Rarely_____	Occasionally _____	Frequently _____
Winter sports (cross country skiing, downhill skiing, ice skating)	Never/Rarely_____	Occasionally _____	Frequently _____
Other (list):	Never/Rarely_____	Occasionally _____	Frequently _____

I certify that I have reviewed the foregoing information supplied by me and it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics to furnish the Government a complete transcript of my medical record for purposes of processing my application. I have read the privacy statement at the beginning of this questionnaire and understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

Sign your name and enter today's date in the space provided below:

Candidate Signature Date (mm/dd/yyyy)

FOR MEDICAL PERSONNEL ONLY

Print Name:

Signature:

Medical Personnel Signature Date (mm/dd/yyyy)

Print Name:

Signature:

Medical Personnel Co-Signature *(If required)* Date (mm/dd/yyyy)