Guide to Completing the Report of Physical Examination

Getting it right the first time: Answers to commonly asked questions.

Page 4: Measurements and Other Findings

1) **Hearing:** Please ask the doctor to note either normal or abnormal after performing the following whisper test:

   - The doctor stands at arms-length behind you.
   - Cover your right ear.
   - Ask doctor to whisper 2-3 numbers towards your left ear.
   - Repeat what you heard the doctor say.
   - Repeat test covering the left ear.
   - Your hearing is normal if you respond correctly each time.

Page 4: Clinical Examination

1) **Please document either *normal* or *abnormal* to <u>all</u> applicable questions.** The only questions that may not be applicable are the gender and age-specific questions, 12 and 15.

Page 4: Laboratory Evaluation

1) **Tuberculin Test:** If you choose to submit results from the *PPD* test, please submit them in mm of induration (in number terms). Do not report "negative" as negative means different things to different doctors.

2) **Lab Reports:** Please ask the doctor for a copy of all lab results for the 8 lab tests listed under *Other Required Lab Tests*.

Page 5: Immunizations Required for Medical Qualification

You must provide documentation that you have had all these immunizations in the noted timeframes (where applicable) even if your doctor feels they are unnecessary.

Page 5: Immunization History

Please provide documentation for all immunizations in this section that you have previously had. Peace Corps will provide all other immunizations needed once you become a Peace Corps Volunteer.

Page 6: Signature

This form must be signed or co-signed by an MD (Medical Doctor) or DO (Doctor of Osteopathy).

Peace Corps Report of Physical Examination

PC-OMS-1790 S

Name (Last, First, Middle Initial) Sex M ❒ F ❒

Social Security Number

Date of Birth (MO / DAY / YR) / /

Current Address **Until** / /

Home/Permanent Address

Telephone No. ( )

Telephone No. ( )

Email

All sections must be completed

THIS SECTION TO BE COMPLETED BY APPLICANT

IV. Health History

A. Symptoms experienced within the past 12 months

Applicant: Answer each question by checking either Yes or No.
Physician: Please review this list. If any are marked "yes," please consider this a current problem requiring further comment or work-up. Use space provided in Section X on page 6 (Summary and Comments) or additional pages if necessary, identified with the applicant's name and social security number.

Symptoms or problems	No	Yes (Resolved)	Yes (Current)	Physician comments
Frequent or severe headaches	❒	❒	❒	
Fainting spells, blackouts or seizures	❒	❒	❒	
Vision problems (e.g., eye injuries, disorders, inflammation)	❒	❒	❒	
Hearing problems/loss	❒	❒	❒	
Persistent cough	❒	❒	❒	
Chest pain or chest pressure	❒	❒	❒	
Shortness of breath or wheezing	❒	❒	❒	
Repeated episodes of indigestion, heartburn, or stomach pain	❒	❒	❒	
Frequent diarrhea or constipation (such as colitis, irritable bowel syndrome)	❒	❒	❒	
Frequent or bloody stools (such as Crohns disease)	❒	❒	❒	
Frequent or painful urination	❒	❒	❒	
Blood in urine	❒	❒	❒	
Repeated episodes of back or neck pain	❒	❒	❒	
Muscle, bone, or joint injuries	❒	❒	❒	
Painful or swollen joints	❒	❒	❒	
Breast lump or mass or nipple discharge	❒	❒	❒	
Skin problems (e.g., eczema, dermatitis, psoriasis)	❒	❒	❒	
Change in color or size of a mole or other growth	❒	❒	❒	
A sore that does not heal	❒	❒	❒	
Frequent sadness or feelings of depression	❒	❒	❒	
Frequent or severe nervousness or anxiousness	❒	❒	❒	
Frequent sleeplessness or insomnia	❒	❒	❒	
Use of cigarettes or other tobacco products	❒	❒	❒	
Chest palpitations	❒	❒	❒	
Easy bleeding or bruising	❒	❒	❒	
Swollen glands in neck	❒	❒	❒	
Swelling in arms or legs	❒	❒	❒	
(Females) Gynecologic symptoms or disorders	❒	❒	❒	
(Males) Lumps in testicles	❒	❒	❒	
(Males) Difficulty starting urine stream or a decreased urine stream	❒	❒	❒	
Other (please specify) _____	❒	❒	❒	
Traumatic injuries (including accidents motor vechicle, sports related, please specify) _____	❒	❒	❒	
Hospitalizations (please specify) _____	❒	❒	❒	
Surgeries (please specify)	❒	❒	❒	

Name of surgery _____ Date of surgery _____

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B. Family history

List family members (mother, father, siblings) who have had any of the following illnesses or problems:

- ❑ Alcoholism _____
- ❑ Diabetes _____
- ❑ Cancer _____
- ❑ High blood pressure _____
- ❑ Cardiovascular disease _____
- ❑ Mental illness _____
- ❑ Kidney Disease _____
- ❑ Sudden death of a relative under age of 50 _____ *(Other than trauma)*
- ❑ **None**
- ❑ Other (specify) _____

C. List all current medications, including over-the-counter medications/supplements and herbals.

Please note, whenever possible, Peace Corps provides a generic equivalent and does not provide medications/supplements considered not medically necessary.

Name	Start Date	Dose	Frequency	Condition Being Treated

❑ **None**

D. Allergies and hypersensitivities

List Allergies	Medications, foods, and insect stings	Description of Reaction	Treatment	Did treatment require an ER visit?	Date of last reaction
				❑ yes ❑ no	
				❑ yes ❑ no	
				❑ yes ❑ no	
				❑ yes ❑ no	
				❑ yes ❑ no	
				❑ yes ❑ no	

❑ None

*** Important *** *I certify that the above information is accurate and complete. I understand that the Peace Corps may verify the information provided by me and my doctors. I understand that withholding or providing false or incomplete information will delay processing my application and may result in disqualification from or termination of Peace Corps service.*

HIPAA and Privacy Act Notice

This information is collected under the authority of the Peace Corps Act, 22 U.S.C. 2501 et seq., for the purposes of determining medical and other eligibility for Peace Corps service. Disclosure of this information is voluntary, but without it the Peace Corps will be unable to provide a medical clearance for service. This information may be used for the routine uses described in the Privacy Act, 5 USC 552a, and in the Federal Register at 65 Fed. Reg. 53,722 (September 5, 2000) and 50 Fed. Reg. 1950, 1962 (January 14, 1985) regarding the Peace Corps system of records PC-17 (Volunteer Records). It may also be used in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and any currently effective authorizations.

_____
Signature

_____
Date

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V. Measurements and Other Findings

Height	Weight	Blood Pressure	Pulse	Hearing	Gross Vision	
					Uncorrected	Corrected
					Right 20/____	Right 20/____
					Left 20/____	Left 20/____
feet/inches	lbs.	(resting)	bpm (resting)	whisper test or other gross test	complete prescription for eyeglass form if uncorrected vision of 20/40 or greater	

VI. Clinical Examination

All Sections MUST be completed by examining physician

Check each item in appropriate column.
All systems must be examined.

Prior to this visit have you provided medical care to this applicant?
❑ yes ❑ no
If yes, how many times in the past 12 months have you seen this applicant?
_____

Notes: Describe each abnormality in detail. Enter item number before each comment. Use additional sheets if necessary.

Normal	Abnormal	
❑	❑	1. Head and neck
❑	❑	2. Nose, sinuses
❑	❑	3. Mouth and throat
❑	❑	4. Thyroid
❑	❑	5. Ears
❑	❑	6. Eyes (include fundoscopic exam)
❑	❑	7. Lungs and chest
❑	❑	8. Breasts
❑	❑	9. Cardiac (rate, rhythm, heart sounds)
❑	❑	10. Peripheral pulses
❑	❑	11. Abdomen
❑	❑	12. Prostate exam (men over 50 only)
❑	❑	13. Anus and rectum
❑	❑	14. Genitalia (include hernia)
❑	❑	15. Pelvic exam (females only)
❑	❑	16. Spine
❑	❑	17. Musculoskeletal
❑	❑	18. Neurologic
❑	❑	19. Skin, lymphatics
❑	❑	20. Identifying marks, scars, tattoos
❑	❑	21. Psychiatric (specify any significant cognitive or behavioral observations)

VII. Laboratory Evaluation

Abnormal lab results require an explanation, a treatment plan or, if chronic abnormality, historical results with a plan for follow up.

PAP Smear cytology results

Date _____

Lab report peformed no more than 1 year prior to the physical exam MUST be attached

Tuberculin Test

TB test performed no more than 6 months prior to physical exam

❑ PPD

Date read _____

Size of induration must be recorded in box below.
Do not report "Negative"

mm of induration

OR

❑ QuantiFERON® - TB gold *(lab report must be attached)*
❑ negative ❑ positive

Other Required Lab Tests

Lab report peformed no more than 6 months prior to the physical exam MUST be attached

❑ HIV (bloodwork or rapid oral test)
❑ CBC
❑ Hepatitis B surface Antibody
❑ Hepatitis B surface Antigen
❑ Hepatitis B core Antibody
❑ Hepatitis C Antibody
❑ G6PD titer
❑ Urinalysis

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VIII. Immunizations Required for Medical Qualification:

Physician - Initial & Date Administration

Type of Immunization	Date of Immunization	Physician Initials
1. Td or Tdap Booster (within 5 years of the Report of Medical Examination)		
2. Polio Booster (after age 18 or documentation by physician of having had the disease)		
3. MMR#1		
4. MMR#2 Booster		
If born before 1957, may instead provide documentation of one measles-containing vaccine, documentation of physician-diagnosed measles, or documentation of titers demonstrating immunity to all 3 diseases. If born 1957 or after, may instead provide documentation of titers demonstrating immunity to all 3 diseases.		
5. Varicella #1		
6. Varicella #2		
If born before 1980, may instead provide documentation of physican-diagnosed chicken-pox or herpes zoster. If born 1980 or after, may instead provide titers demonstrating immunity to varicella.		

Immunization History: Do NOT Give These Immunizations.

Has the applicant received the following immunizations?

If yes to any of the following, please attach copy of the immunization records.

	Yes	No
1. Yellow Fever	❑	❑
2. Hep B Series	❑	❑
3. Hep A Series	❑	❑
4. Typhoid	❑	❑
5. Rabies Pre-Exposure	❑	❑
6. Meningococcal	❑	❑
7. Japanese Encephalitis	❑	❑
8. Tick-borne Encephalitis	❑	❑
9. Influenza	❑	❑
10. Pneumococcal	❑	❑
11. Other (please specify)	❑	❑

IX. Required Tests for Female Applicants 40 Years and Older.

Mammogram (females only)

(Attach radiology report performed no more than 1 year prior to physical exam)

Tests for Applicants 50 Years and Older.

Colorectal Screening (any ONE test) *(Results must be attached)*

- ❑ Colonoscopy *(within 10 years)*
- ❑ Flexible Sigmoidoscopy *(within 5 years)*
- ❑ Double Contrast Barium Enema *(within 5 years)*
- ❑ CT Colonography "Virtual Colonoscopy" *(within 5 years)*
- ❑ Stool DNA Testing *(within 1 year)*
- ❑ Fecal Immunochemical Test (FIT) *(within 1 year)*
- ❑ Fecal Occult Blood Test (FOBT)x3 - Stool for occult blood *(within 1 year)*

❑ **ECG Interpretation**

(ECG tracing performed no more than 1 year prior to the physical exam MUST be faxed to Peace Corps at 202.692.1561)

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X. Summary of the Medical Examination and Additional Comments

Provide your summary and assessment of the medical examination. Comment on all abnormal findings including recommendations for evaluation and/or treatment required for the next three years of service in a developing country. If additional pages are required, include applicant's name and social security number on each page.

List all **Active** and **Chronic** Conditions	Recommendations & Comments
1	
2	
3	
4	
5	
6	

1. Do you have any medical concerns about the applicant that might limit his/her assignment to a specific geographic area (e.g. mountainous terrain, high altitude, sun exposure, harsh environmental or climatic conditions, etc?) YES ❑ NO ❑ If yes, specify

(must be signed or co-signed by a licensed M.D. or D.O. if exam performed by other than M.D. or D.O.)

*** Important *** **Medical examination is complete only when:**

- Applicant has signed and dated statement on page 3.
- Physician has signed and dated page 6.
- Physician has initialed all documented immunizations on page 5.
- Required lab reports are attached.
- PAP, ECG tracing and mammography report are attached (when indicated).

Physician Signature/Title

Physician Name (Print)

Date

Physician License Number/State

Physician Address and Phone Number

INCOMPLETE FORMS WILL BE RETURNED TO THE APPLICANT AND WILL DELAY PROCESSING!