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):*
Polar Medical Staff Use Only Reviewed by:_________ Date: ________________	*Restrictions and Follow-up:* ________________________________ ________________________________ *Reason for NPQ:* ________________________________ ________________________________

Name: last, first, middle (must match passport)	Age:	Birth date (MM/DD/YY):	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 ☐ CH2M HILL ☐ 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 (specify): ____________________	**Proposed Arctic Season and Worksite**: ☐ Summer (Mar-Sep) ☐ Winter (Oct-Feb) ☐ Summit ☐ Alaska____________________________ ☐ USCGC Healy ☐ Field Camp ______________________________ ☐ Other:___________________________________

NAME________________________________ DOB _______________________

CURRENT MEDICATIONS						
Name	**Dose**	**Frequency**		**Name**	**Dose**	**Frequency**

ALLERGIES				
Name	**TYPE OF REACTION**		**Name**	**TYPE OF REACTION**

PAST HOSPITALIZATIONS				
Condition	**Date**		**Condition**	**Date**

PAST SURGERIES				
Condition	**Date**		**Condition**	**Date**

MEDICAL TESTING/PROCEDURES IN PREVIOUS 3 YEARS		
Type (specify body location)	**Date**	***Describe: reason for test procedure and result***
MRI		
CT		
Ultrasound		
Angiogram		
Biopsy		
Other		

IMMUNIZATION HISTORY						
	Date – most recent immunization			**Dates of immunization**		
Influenza			Hepatitis A			
DT			Hepatitis B			
DPT			Other (specify)			
Pneumococcus						

NAME________________________________ DOB _______________________

SOCIAL HISTORY			
Tobacco	**yes**	**no**	Describe: Packs/week Total yrs. Year last
Do you currently use tobacco products?			
Have you used tobacco products in the past?			
Alcohol	**yes**	**no**	
Do you drink alcohol?			
If abstinent, please enter date of your last alcoholic beverage:			
Have you ever felt you should decrease your alcohol consumption?			Describe:
Have you ever received a DUI, DWAI or court ordered treatment for alcohol?			
Have you been diagnosed as an alcoholic?			
Exercise and conditioning	**yes**	**no**	Describe:
Do you have a regular exercise program?			
Have you had a cardiovascular stress test?			Date of last treadmill:

GENERAL MEDICAL HISTORY

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY

	Condition	*Yes*	*No*		*Condition*	*Yes*	*No*
1	**Neurology**			2E	Coronary angioplasty/stent/bypass		
1A	Cerebrovascular accident (CVA)			2F	Coronary artery disease		
1B	Concussion			2G	Heart murmur/valvular heart disease		
1C	Dizziness/Loss of Consciousness			2H	Hypertension (high blood pressure)		
1D	Headaches (Migraine)			2I	Myocardial Infarction (MI)		
1E	Headaches (Other)			2J	Supraventricular tachycardia (SVT)		
1F	Multiple sclerosis			2K	Other cardiac condition		
1G	Peripheral neuropathy			**3**	**Vascular disease**		
1H	Seizures			3A	Abdominal aneurysm		
1I	Transient ischemic attack (TIA)			3B	Arterial emboli		
1J	Traumatic brain injury (TBI)			3C	Cerebral aneurysm		
1K	Other neurological disorder			3D	Deep venous thrombosis (DVT)		
2	**Cardiology**			3E	Venous stasis ulcers		
2A	Angina/chest pain			3F	Other vascular condition		
2B	Atrial fibrillation			**4**	**Rheumatologic disease**		
2C	Cardiac pacemaker/defibrillator			4A	Fibromyalgia		
2D	Congestive heart failure			4B	Osteoarthritis		

For all "yes" answers, please provide details to include age of onset, frequency of event, date of last episode, current medications, other therapies and status of the condition.

NAME________________________________ DOB ______________________

GENERAL MEDICAL HISTORY

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY

Condition		Yes	No	Condition		Yes	No
4	**Rheumatologic disease (cont'd)**			**9**	**Dermatology**		
4C	Rheumatoid arthritis			9A	Dermatitis		
4D	Systemic Lupus erythematosis			9B	Melanoma		
4E	Other rheumatologic condition			9C	Psoriasis/Eczema		
5	**Ears Nose and Throat**			9D	Skin cancer		
5A	Hearing impairment			9E	Other skin condition		
5B	Nosebleeds			**10**	**Orthopedic**		
5C	Seasonal Allergies			10A	Cervical spine injury		
6	**Ophthamology**			10B	Chronic pain		
6A	Glaucoma			10C	Dislocation		
6B	Visual impairment			10D	Fractures		
6C	Other eye condition			10E	Low back injury		
7	**Pulmonary**			10F	Orthopedic pins/plates		
7A	Altitude sickness			10G	Other orthopedic condition		
7B	Asthma			**11**	**Metabolic**		
7C	Chronic bronchitis/bronchiectasis			11A	Adrenal insufficiency		
7D	Chronic obstructive pulmonary disease			11B	Diabetes Type I		
7E	Dyspnea (shortness of breath)			11C	Diabetes Type II		
7F	Obstructive sleep apnea			11D	Gout		
7G	Pulmonary embolism			11E	Hypercholesterolemia		
7H	Other pulmonary condition			11F	Hyperthyroidism		
8	**Gastrointestinal disease**			11G	Hypothyoidism		
8A	Black tarry stools			11H	Pituitary insufficiency		
8B	Blood in stool			11I	Other hormonal disorder		
8C	Cholelithiasis (gallstones)			**12**	**Gynecology-female**		
8D	Crohn's disease			12A	Menstrual period in past 30 days		
8E	Frequent or persistent diarrhea			12B	Date of last PAP smear		
8F	Gastroesophageal reflux (GERD)			12C	Premenstrual syndrome (PMS)		
8G	Hemorrhoids			12D	Endometriosis		
8H	Hepatitis (describe type)			12E	Severe menstrual cramps		
8I	Hernia			12F	Ovarian cysts		
8J	Irritable bowel syndrome (IBS)			12G	Sexually transmitted disease		
8K	Pancreatitis			12H	Other gynecological conditions		
8L	Peptic ulcer disease						
8M	Ulcerative colitis						
8N	Other gastrointestinal disease						

For all "yes" answers, please provide details to include age of onset, frequency of event, date of last episode, current medications, other therapies and status of the condition.

NAME________________________________ DOB ______________________

GENERAL MEDICAL HISTORY							
ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY							
Condition		*Yes*	*No*	*Condition*		*Yes*	*No*
13	**Psychiatric**			**16**	**Genitourinary - male**		
13A	Addiction			16A	Prostate disease		
13B	Anxiety/panic attacks			16B	Sexually transmitted disease		
13C	Attention deficit disorder			16C	Testicular abnormality		
13D	Bipolar			16D	Other genitourinary condition		
13E	Depression						
13F	Eating disorder (bulimia/anorexia)						
13G	Hospitalization for psych condition						
13H	Post traumatic stress disorder						
13I	Schizophrenia						
13J	Other psychiatric condition						
14	**Renal disease**						
14A	Chronic Renal Disease						
14B	Frequent urinary tract infections						
14C	Hematuria (blood in urine)						
14D	Kidney stones						
14E	Other kidney condition						
15	**Hematology/Oncology**						
15A	Anemia						
15B	Cancer (describe type)						
15C	Leukemia						
15D	Lymphoma - Hodgkins						
15E	Lymphoma – non Hodgkins						
15F	Platelet disorder						
15G	Other hematologic/oncologic						

For all "yes" answers, please provide details to include age of onset, frequency of event, date of last episode, current medications, other therapies and status of the condition.

rtify 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 ical/health changes, including medications, that occur after submitting this form. I understand that failure to provide any or all of the requested informatio 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 i esentatives is a criminal offense.

_____________________________ _____________________________ ______________

Print Name ***Signature*** ***Date***