

NATIONAL SCIENCE FOUNDATION - POLAR PHYSICAL EXAMINATION

**MEDICAL HISTORY**

<p><i>Complete pages 1-5 in ink prior to Dr.'s exam</i></p>	<p><b>Polar Medical Staff Use Only</b></p> <p>Date: _____ <input type="checkbox"/> PQ <input type="checkbox"/> PQ Summer Only <input type="checkbox"/> NPQ</p> <p>Medical Condition(s):</p> <hr/>		
<p><b>Polar Medical Staff Use Only</b></p> <p>Reviewed by: _____</p> <p>Date: _____</p>	<p><b>Restrictions and Follow-up:</b></p> <hr/> <hr/> <p>Reason for NPQ:</p> <hr/> <hr/>		
<p>Name: last, first, middle (must match passport)</p>	<p>Age:</p>	<p>Birth date (MM/DD/YY):</p>	<p>Sex: <input type="checkbox"/> F <input type="checkbox"/> M</p>
<p>Nickname (aka)</p>	<p>Maiden Name:</p>	<p>Previous Name or Other Legal Name:</p>	
<p>Street</p>	<p>City</p>	<p>State</p>	<p>Zip</p>
<p>Telephone (include area code):</p>			
<p>Day:</p>	<p>Evening:</p>	<p>Mobile:</p>	<p>E-Mail:</p>
<p>Emergency Point of Contact (Name, Address and Phone Number):</p>			
<p><b>Job Title:</b></p>	<p><b>Current Deployment Dates:</b></p> <p>From _____ to _____</p>	<p><b>Previous Polar (Arctic or Antarctic) Deployment?</b></p> <p>Dates: _____</p> <p>Location: _____</p>	
<p><b>Affiliation:</b> <input type="checkbox"/> NSF</p> <p><input type="checkbox"/> Science Event # _____</p> <p><input type="checkbox"/> Technical Event # _____</p> <p><input type="checkbox"/> RPSC</p> <p><input type="checkbox"/> CH2M HILL</p> <p><input type="checkbox"/> Other: _____</p>	<p><b>Proposed Antarctic Season and Worksite:</b></p> <p><input type="checkbox"/> Summer (Sep-Feb)</p> <p><input type="checkbox"/> Winter (Mar-Oct)</p> <p><input type="checkbox"/> Winfly _____ (dates)</p> <p><input type="checkbox"/> McMurdo Station</p> <p><input type="checkbox"/> South Pole Station</p> <p><input type="checkbox"/> Palmer Station</p> <p><input type="checkbox"/> RV/NB Palmer</p> <p><input type="checkbox"/> RV/LM Gould</p> <p><input type="checkbox"/> Field Camp _____</p> <p><input type="checkbox"/> Other (specify): _____</p>	<p><b>Proposed Arctic Season and Worksite:</b></p> <p><input type="checkbox"/> Summer (Mar-Sep)</p> <p><input type="checkbox"/> Winter (Oct-Feb)</p> <p><input type="checkbox"/> Summit</p> <p><input type="checkbox"/> Alaska _____</p> <p><input type="checkbox"/> USCGC Healy</p> <p><input type="checkbox"/> Field Camp _____</p> <p><input type="checkbox"/> Other: _____</p>	

NAME \_\_\_\_\_

DOB \_\_\_\_\_

CURRENT MEDICATIONS						
Name	Dose	Frequency		Name	Dose	Frequency

ALLERGIES			
Name	TYPE OF REACTION		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 \_\_\_\_\_

<b>SOCIAL HISTORY</b>							
<b>Tobacco</b>		<b>ye s</b>	<b>no</b>	Describe: Packs/week    Total yrs.    Year last			
Do you currently use tobacco products?							
Have you used tobacco products in the past?							
<b>Alcohol</b>		<b>ye s</b>	<b>no</b>				
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?							
<b>Exercise and conditioning</b>		<b>yes</b>	<b>no</b>	Describe:			
Do you have a regular exercise program?				Date of last treadmill:			
Have you had a cardiovascular stress test?							
<b>GENERAL MEDICAL HISTORY</b>							
<b>ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY</b>							
<i>Condition</i>		<i>Yes</i>	<i>No</i>	<i>Condition</i>		<i>Yes</i>	<i>No</i>
<b>1</b>	<b>Neurology</b>			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			<b>3</b>	<b>Vascular disease</b>		
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)		
<b>2</b>	<b>Cardiology</b>			3E	Venous stasis ulcers		
2A	Angina/chest pain			3F	Other vascular condition		
2B	Atrial fibrillation			<b>4</b>	<b>Rheumatologic disease</b>		
2C	Cardiac pacemaker/defibrillator			4A	Fibromyalgia		
2D	Congestive heart failure			4B	Osteoarthritis		
<p><i>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.</i></p>							

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GENERAL MEDICAL HISTORY					
ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY					
Condition		Yes	No	Condition	
<b>4</b>	<b>Rheumatologic disease (cont'd)</b>			<b>9</b>	<b>Dermatology</b>
4C	Rheumatoid arthritis			9A	Dermatitis
4D	Systemic Lupus erythematosus			9B	Melanoma
4E	Other rheumatologic condition			9C	Psoriasis/Eczema
<b>5</b>	<b>Ears Nose and Throat</b>			9D	Skin cancer
5A	Hearing impairment			9E	Other skin condition
5B	Nosebleeds			<b>10</b>	<b>Orthopedic</b>
5C	Seasonal Allergies			10A	Cervical spine injury
<b>6</b>	<b>Ophthalmology</b>			10B	Chronic pain
6A	Glaucoma			10C	Dislocation
6B	Visual impairment			10D	Fractures
6C	Other eye condition			10E	Low back injury
<b>7</b>	<b>Pulmonary</b>			10F	Orthopedic pins/plates
7A	Altitude sickness			10G	Other orthopedic condition
7B	Asthma			<b>11</b>	<b>Metabolic</b>
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
<b>8</b>	<b>Gastrointestinal disease</b>			11G	Hypothyroidism
8A	Black tarry stools			11H	Pituitary insufficiency
8B	Blood in stool			11I	Other hormonal disorder
8C	Cholelithiasis (gallstones)			<b>12</b>	<b>Gynecology-female</b>
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.*

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**GENERAL MEDICAL HISTORY**

**ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY**

<i>Condition</i>		<i>Yes</i>	<i>No</i>	<i>Condition</i>		<i>Yes</i>	<i>No</i>
<b>13</b>	<b>Psychiatric</b>			<b>16</b>	<b>Genitourinary - male</b>		
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						
<b>14</b>	<b>Renal disease</b>						
14A	Chronic Renal Disease						
14B	Frequent urinary tract infections						
14C	Hematuria (blood in urine)						
14D	Kidney stones						
14E	Other kidney condition						
<b>15</b>	<b>Hematology/Oncology</b>						
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.*

*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, including medications, that occur after submitting this form. I understand that failure to provide any or all of the requested information 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