DEPARTMENT OF HOMELAND SECURITY

OMB 1652-0032

Exp. 7/31/2019

Transportation Security Administration

**TRANSPORTATION SECURITY OFFICER**

**MEDICAL QUESTIONNAIRE**

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| **INSTRUCTIONS:**  It is required that you personally 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 and print and sign your name on the last page. Your responses will be reviewed with you by a medical professional. | |
| **It is recommended that you review the TSO Medical Guidelines prior to taking the medical assessment. The medical guidelines can be found at** [**https://hraccess.tsa.dhs.gov/hraccess/pdf/TSO\_Medical\_Guidelines.pdf**](https://hraccess.tsa.dhs.gov/hraccess/pdf/TSO_Medical_Guidelines.pdf)**. Consider bringing medical records/documentation regarding any chronic diseases or medical conditions, such as recent lab reports or stress test results to your medical exam appointment.** **For purposes of this examination, please do not include any genetic information, including family medical history or the results of any genetic testing, with any medical records/documentation you provide. NOTE TO MEDICAL EXAMINER: Please do not collect any genetic information provided by the examinee.** | |
| **SECTION I. DEMOGRAPHIC INFORMATION Candidate Initials** \_\_\_\_\_\_\_\_\_ | |
| **Name (Print):** | **LAST 4 OF SSN: XXX – XX - \_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **SEX: Male \_\_\_\_\_\_\_\_ Female \_\_\_\_\_\_\_\_** |  |
| **Address:** |
| **City, State, Zip:** |
| **Primary Phone: ( ) –** | **Date of Birth (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Secondary Phone: ( ) –** |
| **Other Phone: : ( ) –** | **Height: Feet \_\_\_\_\_\_ Inches \_\_\_\_\_\_ Weight \_\_\_\_\_\_\_** |
| **Best Time to Call:** |
| **SECTION II. GENERAL INFORMATION** | |
| 1. Have you been refused employment, dismissed from a job, or unable to stay in school due to any 1. YES \_\_\_\_ NO \_\_\_\_  medical condition or excessive absenteeism?  **If YES**, please list each medical condition and the year of the refusal/dismissal:  1. MO/YR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2. MO/YR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3. MO/YR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2. Have you had any operations and/or medical procedures? 2. YES \_\_\_\_ NO \_\_\_\_  **If YES**, describe and indicate date:  1. MO/YR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2. MO/YR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3. MO/YR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3. Have you had a visit to a clinic, physician, chiropractor, ER, urgent care, outpatient facility, 3. YES \_\_\_\_\_ NO \_\_\_\_\_  physical therapist, healer, acupuncturist, or any other practitioner within the past year?  **If YES**, specify condition and healthcare provider consulted, and indicate date:  1. MO/YR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2. MO/YR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3. MO/YR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | | **EXAMINER COMMENTS – GENERAL INFORMATION:** | | *Examiner MUST enter a comment on all positive history / “yes” answers.* | | |
| **SECTION II. (continued) Candidate Initials** \_\_\_\_\_\_\_\_\_ | |
| 4. Are you currently taking any **prescription** medications? 4. YES \_\_\_\_ NO \_\_\_\_  **If YES**, complete box below. If medication is “as needed” specify approximate frequency. Use back of paper as needed.   |  |  |  |  |  | | --- | --- | --- | --- | --- | | NAME OF MEDICATION | REASON FOR MEDICATION | DOSE | Frequency: How often do you take each (daily, nightly, etc.)? | DATE of LAST DOSE | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |   5. Are you currently taking any **non- prescription OTC** medications/herbs/supplements? 5. YES \_\_\_\_ NO \_\_\_\_  **If YES**, complete box below. If medication is “as needed” specify approximate frequency. Use back of paper as needed.   |  |  |  |  |  | | --- | --- | --- | --- | --- | | NAME OF MEDICATION | REASON FOR MEDICATION | DOSE | Frequency: How often do you take each (daily, nightly, etc.)? | DATE of LAST DOSE | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  | | --- | | **EXAMINER COMMENTS – GENERAL INFORMATION:** | | *Examiner MUST enter a comment on all positive history / “yes” answers. Ensure all sections of medication tables are complete.* | | |
| **SECTION III. VISION AND HEARING** | |
| 6. Do you have known uncorrectable vision loss or a total loss of vision in either eye?................. 6. YES \_\_\_\_\_ NO\_\_\_\_\_\_  **If YES**, indicate date of onset:………………………………………………Date: MO/YR \_\_\_\_\_\_\_    7. Have you had any type of refractive eye surgery such as LASIK, PRK, etc.?.............................. 7. YES \_\_\_\_\_ NO\_\_\_\_\_\_  **If YES**, answer below:   1. Type of surgery: Date: MO/YR \_\_\_\_\_\_\_\_\_\_\_ 2. Do you have any dryness that affects your vision?............................. YES \_\_\_\_\_ NO\_\_\_\_\_\_ 3. Do you use steroid eye drops? ………………………………………….. YES \_\_\_\_\_ NO\_\_\_\_\_\_   8. Do you use a hearing aid for either ear?......……………………………………………………….. 8. YES \_\_\_\_\_ NO\_\_\_\_\_\_   |  | | --- | | **EXAMINER COMMENTS – VISION and HEARING:** | | *Examiner MUST enter a comment on all positive history / “yes” answers.* | | |
| **SECTION IV. RESPIRATORY Candidate Initials** \_\_\_\_\_\_ | |
| 9. Do you have asthma?................................................................................................................ 9. YES \_\_\_\_\_ NO\_\_\_\_\_\_  10. Do you have chronic obstructive pulmonary disease (COPD)?.................................................. 10. YES \_\_\_\_\_ NO\_\_\_\_\_\_  11. Do you have blood in sputum when coughing?.......................................................................... 11. YES \_\_\_\_\_ NO\_\_\_\_\_\_    12. Have you EVER had active tuberculosis (not just a positive skin test)? …………………………12. YES NO  **If YES**, answer the questions below:   1. When was your last Chest X-Ray?........................................................... Date: MO/YR \_\_\_\_\_\_\_\_ 2. When were you treated?........................................................................... Date: MO/YR \_\_\_\_\_\_\_\_ 3. How long was your treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   13. Have you ever had any other lung disease? ………………………………………………………. 13. YES \_\_\_\_\_ NO\_\_\_\_\_\_  **If YES**, specify disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | | **EXAMINER COMMENTS – RESPIRATORY:** | | *Examiner MUST enter a comment on all positive history / “yes” answers.* | | |
| **SECTION V. CARDIOVASCULAR** | |
| Have you ever had or experienced any of the following?  14. Hypertension? …………………………………………………………………………………………..14. YES \_\_\_\_\_ NO\_\_\_\_\_\_  **If YES**, answer the questions below and **Go to** **APPENDIX A** **at the end of this document to provide complete information**:   1. Have you had a treadmill exercise stress test? …………………………… YES \_\_\_\_\_ NO\_\_\_\_\_\_   If **YES**, date of most recent? ………………… MO/YR  Was it normal? ………………………………… YES NO Don’t know \_\_\_\_\_\_\_  What METS did you reach? ……..……………. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Don’t know \_\_\_\_\_\_\_   1. Have you had any complications of hypertension, such as, stroke, coronary artery disease, left ventricular hypertrophy, atrial fibrillation, heart failure, nephropathy, retinopathy, or aortic aneurysm? YES \_\_ NO \_\_\_\_\_   List the complication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Complete APPENDIX A at the end of this document.**  15. Coronary artery disease, heart attack, open heart surgery, stent, or angioplasty? ……………..15. YES \_\_\_\_\_ NO\_\_\_\_\_\_  **If YES**, answer the questions below:   1. Indicate MO/YR or Not applicable (NA):   Heart attack \_\_\_\_\_\_\_\_\_\_\_\_ Open heart surgery \_\_\_\_\_\_\_\_\_\_\_\_ Stent or angioplasty \_\_\_\_\_\_\_\_\_\_\_\_   1. Have you had a treadmill exercise stress test with imaging?................... YES \_\_\_\_\_\_ NO \_\_\_\_\_\_   Date of most recent? ………………………… MO/YR  Was it normal? ………………………………… YES NO Don’t know \_\_\_\_\_\_\_  What METS did you reach? ...…………………\_\_\_\_\_ \_\_\_\_\_\_\_\_ Don’t know \_\_\_\_\_\_\_   1. Do you have chest pain with exertion or activity? ………………………... YES \_\_\_\_\_\_ NO \_\_\_\_\_\_ 2. Are your risk factors being treated (smoking, hypertension, cholesterol, obesity, etc.)? YES \_\_\_\_\_ NO \_\_\_\_\_ 3. When was your last heart medication change? ……………………….. MO/YR \_\_\_\_\_\_\_\_\_\_ 4. Have you been compliant with treatment? ………………………………... YES NO \_\_\_\_\_\_ | |
| **SECTION V. (continued) Candidate Initials** \_\_\_\_\_\_ | |
| 16. Heart failure? ……….....................................................................................................................16. YES \_\_\_\_\_ NO\_\_\_\_\_\_  **If YES**, answer the question below:   1. Have you had an echocardiogram, or stress echocardiogram? ……….. YES \_\_\_\_\_ NO \_\_\_\_\_   **If YES**, indicate the ejection fraction if known: ……………… % Don’t know \_\_\_\_\_\_\_\_  17. Cardiomyopathy? ………………………………………………………………………………………..17. YES \_\_\_\_\_ NO\_\_\_\_\_\_  18. Atrial fibrillation, atrial flutter, supraventricular tachycardia, Wolff-Parkinson-White Syndrome, or ventricular tachycardia?    ………………………………………………………………………………………………………………..…………..18. YES \_\_\_\_\_ NO\_\_\_\_\_\_  **If YES**, answer the questions below:   1. Did you have an ablation? .………………………………………………… YES \_\_\_\_\_ NO \_\_\_\_\_   Date(s) of ablation? ………………………………………………………….. MO/YR \_\_\_\_\_\_\_\_  Was it successful? …………………………………………………………… YES \_\_\_\_\_ NO \_\_\_\_\_   1. Have you had an echocardiogram, or stress echocardiogram? ……….. YES \_\_\_\_\_ NO \_\_\_\_\_   **If YES**, indicate the ejection fraction if known: ………………….. % Don’t know \_\_\_\_\_   1. Have you had a treadmill exercise stress test with imaging? ……………. YES \_\_\_\_\_ NO \_\_\_\_\_   Date of most recent? …………………………………………………….. MO/YR \_\_\_\_\_\_\_\_\_\_  Was it normal? ………………………………………… YES NO Don’t know \_\_\_\_\_\_\_\_  What METS did you reach? ………………………….. \_\_\_\_\_ \_\_\_\_\_\_\_\_ Don’t know \_\_\_\_\_\_\_\_  19. Ventricular fibrillation? ………………………………………………………………………………….19. YES \_\_\_\_\_ NO \_\_\_\_\_  20. Unexplained syncope (fainting or passing out)? …………………………………………………….20. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, date of last occurrence: …………………………………............................ MO/YR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  21. Pacemaker? ……………………………………………………………………………………………..21. YES \_\_\_\_\_ NO \_\_\_\_\_  22. Valvular heart disease? ………………………………………………………………………………...22. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, specify type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  23. Automatic implantable cardiac defibrillator (AICD)?..………………………………………………..23. YES \_\_\_\_\_ NO \_\_\_\_\_  24. Peripheral vascular disease that causes pain with walking? ……………………………………….24. YES \_\_\_\_\_ NO \_\_\_\_\_  25. Thoracic or abdominal aortic aneurysm? …...………………………………………………………...25. YES \_\_\_\_\_ NO \_\_\_\_\_  26. Other cardiac condition(s) not previously mentioned? ………………………………………………26. YES \_\_\_\_\_ NO \_\_\_\_\_  Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | | **EXAMINER COMMENTS – CARDIOVASCULAR:** | | *Examiner MUST enter a comment on all positive history / “yes” answers.*  *If history of heart failure or cardiomyopathy, what is the NYHA classification, I II III IV:* | | |
| **SECTION VI. ABDOMINAL ORGANS and RENAL Candidate Initials** \_\_\_\_\_\_ | |
| 27. Have you had or do you currently have a hernia? ……………………………………………………27. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, answer questions below:   1. Circle type: inguinal ventral umbilical femoral 2. Has it been repaired? ………………………………………………………. YES \_\_\_\_\_ NO \_\_\_\_\_ 3. Do you have pain, restrictions, or limitations? ………………………….. YES \_\_\_\_\_ NO \_\_\_\_\_   **If YES**, specify limitations/restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  28. Do you have chronic kidney disease (CKD)? …………………………………………………….......28. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, answer the questions below:  a. What is the stage? (circle response) 1 2 3 4 5 Don’t Know \_\_\_\_\_\_  b. What is your most recent GFR? \_\_\_\_\_\_\_\_\_\_\_\_\_mL/min MO/YR \_\_\_\_\_\_\_\_\_\_\_ Don’t Know \_\_\_\_\_\_  29. Are you being treated with hemodialysis or peritoneal dialysis? ….………………………………. 29. YES \_\_\_\_\_ NO \_\_\_\_\_   |  | | --- | | **EXAMINER COMMENTS – ABDOMINAL ORGANS and RENAL:** | | *Examiner MUST enter a comment on all positive history / “yes” answers.* | | |
| **SECTION VII. MUSCULOSKELETAL** | |
| Have you ever had or experienced any of the following?  30. Amputation or congenitally absent body part?..............................................................................30. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, answer below:   1. Specify body part: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Do you use any prosthesis? ……………………………………………. YES \_\_\_\_\_ NO \_\_\_\_\_   31. Do you use any ambulatory aids (crutches, cane, walker, etc.)? …………………………………..31. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  32. Upper extremity condition (hand, wrist, forearm, elbow, upper arm, shoulder)? ………………….32. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  33. Lower extremity condition (foot, ankle, lower leg, knee, upper leg, hip)? ………………………… 33. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  34. Spine condition (back, neck, surgery)? ………………………………………………………………..34. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  35. Joint replacement surgery? …………………………………………………………………………….35. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, provide details and dates: MO/YR \_\_\_\_\_\_\_\_\_   |  | | --- | | **EXAMINER COMMENTS – MUSCULOSKELETAL:** | | *Examiner MUST enter a comment on all positive history / “yes” answers. If examinee has current and temporary physical restrictions (lift, squat, bend, reach overhead, walk, stand, etc.) document how long the restrictions are expected to last; if not known please state.* | | |
| **SECTION VIII. NEUROLOGICAL Candidate Initials** \_\_\_\_\_\_ | |
| Have you **ever** had or experienced any of the following:  36. Cerebrovascular accident (CVA, stroke, brain bleed, or TIA)? ……………………………………..36. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, answer below:   1. Specify type and date: MO/YR \_\_\_\_\_\_\_ 2. Do you have any residual physical, mental, or emotional impairments or limitations? YES \_\_\_\_\_ NO \_\_\_\_\_   **If YES**, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  37. Seizures?………………………………………………………………………………………………….37. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, answer the questions below:   1. Do you have epilepsy?.............................................................................. YES \_\_\_\_\_ NO \_\_\_\_\_ 2. What causes your seizures? Don’t Know \_\_\_\_\_\_\_\_ 3. Date of last seizure? ……………………………………………………. MO/YR \_\_\_\_\_\_\_\_ 4. Date of last evaluation by a neurologist? …………………………….. MO/YR \_\_\_\_\_\_\_\_   38. Vertigo? …………………………………………………………………………………………………. 38. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, specify date of last occurrence: …………………………………... MO/YR \_\_\_\_\_\_\_  39. Meniere’s disease? …………………………………………………………………………………….. 39. YES \_\_\_\_\_ NO \_\_\_\_\_  40. Paralysis of a limb? …………………………………………………………………………………….. 40. YES \_\_\_\_\_ NO \_\_\_\_\_  41. Complete loss of touch sensation in upper extremity? ……………………………………………... 41. YES \_\_\_\_\_ NO \_\_\_\_\_  42. Cognitive impairment (ongoing memory loss, dementia)? ………..………………………………... 42. YES \_\_\_\_\_ NO \_\_\_\_\_  43. Malignancy of the spinal cord or brain? ……………………………………………………………..…43. YES \_\_\_\_\_ NO \_\_\_\_\_  44. Amyotrophic lateral sclerosis? ………………………………………………………………………… 44. YES \_\_\_\_\_ NO \_\_\_\_\_  45. Multiple sclerosis? ………………………………………………………………………………………..45. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, answer questions below:   1. Specify date of diagnosis: …………………………………………….. MO/YR \_\_\_\_\_\_\_ 2. Specify date of last relapse: ………………………………………….. MO/YR \_\_\_\_\_\_\_ 3. Do you have a mood disorder? ……..……………………………….. YES \_\_\_\_\_ NO \_\_\_\_\_   46. Parkinson’s? ……………………………………………………………………………………………...46. YES \_\_\_\_\_ NO \_\_\_\_\_  47. Other neurologic disorder not previously noted? ……………………………………………………...47. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | | **EXAMINER COMMENTS –NEUROLOGICAL:** | | *Examiner MUST enter a comment on all positive history / “yes” answers.* | | |
| **SECTION IX. ENDOCRINE Candidate Initials** \_\_\_\_\_\_ | |
| 48. Do you have diabetes? ………………………………………………………………………………….48. YES \_\_\_\_\_ NO \_\_\_\_\_    **If YES**, answer questions (a) through (o) below and **Go to APPENDIX A at the end of this document to provide complete information**:   1. Are you compliant with your prescribed treatment? ………………………. YES \_\_\_\_\_ NO \_\_\_\_\_ 2. Have you had an episode(s) of hypoglycemia requiring the help of others in the past three years?   YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, specify details and dates:   1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. Have you had diabetic ketoacidosis in the past 12 months? ………..…… YES \_\_\_\_\_ NO \_\_\_\_\_ 4. What was your last hemoglobin A1c? … % Don’t know \_\_\_\_\_\_\_\_\_\_\_\_ 5. When was your last hemoglobin A1c? ……………….….……………….. MO/YR \_\_\_\_\_\_\_\_\_\_\_\_ 6. Have you completed diabetes education? …………………………………. YES \_\_\_\_\_ NO \_\_\_\_\_ 7. Do you self-monitor your blood glucose? …………………………………....YES \_\_\_\_\_ NO \_\_\_\_\_ 8. Do you have lightheadedness with standing? …..………….……………….YES \_\_\_\_\_ NO \_\_\_\_\_ 9. Do you have peripheral neuropathy that interferes with your activity? .......YES \_\_\_\_\_ NO \_\_\_\_\_   **If YES**, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Do you have chronic kidney disease (CKD)? …………..……………………YES \_\_\_\_\_ NO \_\_\_\_\_   **If YES**, specify GFR mL/min Don’t know   1. Have you had a dilated eye exam? …………..……………………………….YES \_\_\_\_\_ NO \_\_\_\_\_   **If YES**, specify last exam date:..…………………….…………………. MO/YR \_\_\_\_\_\_\_\_\_\_\_\_\_   1. Do you have retinopathy? ……………………….……………………………. YES \_\_\_\_\_ NO \_\_\_\_\_ 2. Do you have type 1 diabetes treated with insulin?...................................... YES \_\_\_\_\_ NO \_\_\_\_\_   **If YES**, any change in insulin regimen in the past 6 months? ……….. YES \_\_\_\_\_ NO \_\_\_\_\_   1. Do you have type 2 diabetes treated with insulin? …...…………………......YES \_\_\_\_\_ NO \_\_\_\_\_   **If YES**, any change in insulin regimen in the past 3 months……..........YES \_\_\_\_\_ NO \_\_\_\_\_   1. Do you have type 2 diabetes treated with non-insulin medication? ….........YES \_\_\_\_\_ NO \_\_\_\_\_   **If YES**, any change in medication in the past 30 days? …………........ YES \_\_\_\_\_ NO \_\_\_\_\_  **Complete APPENDIX A at the end of this document.**   |  | | --- | | **EXAMINER COMMENTS – Endocrine:** | | *Examiner MUST enter a comment on all positive history / “yes” answers and ensure Appenix A is complete.* | | |
| **SECTION X. SLEEP DISORDERS Candidate Initials** \_\_\_\_\_\_ | |
| Have you ever had or experienced any of the following:  49. Narcolepsy? ………………………………………………………………………………………………49. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, is it with cataplexy? …………..…………………………………………………… YES \_\_\_\_\_ NO \_\_\_\_\_  50. Obstructive sleep apnea? ……………………………………………………………………………….50. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, answer questions below:   1. Did you have a sleep study? …………..…………………………………. YES \_\_\_\_\_ NO \_\_\_\_\_   **If YES**, What symptoms were you having that prompted the sleep study? (circle all that apply)  Daytime sleepiness Snoring Insomnia  Nocturnal awakenings/not breathing Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Were you prescribed treatment with CPAP? ……….……………………. YES \_\_\_\_\_\_ NO \_\_\_\_\_\_\_   **If YES**, How many days/wk do you wear your CPAP? How many hrs/night? \_\_\_\_\_\_\_\_  (If you have a recent CPAP compliance report, please provide to examiner)  51. Shift work disorder? ………………………………………………………………………………………51. YES \_\_\_\_\_ NO \_\_\_\_\_  52. **If YES** to narcolepsy, sleep apnea, or shift work disorder, what are your current symptoms from these conditions?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | | **EXAMINER COMMENTS – SLEEP DISORDERS:** | | *Examiner MUST enter a comment on all positive history / “yes” answers.* | | |
| **SECTION XI. PSYCHOLOGICAL** | |
| Have you ever had or experienced any of the following:  53. Anxiety disorder? …………………………………………………………………………………………53. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, date of last occurrence of symptoms? ………………………………………... MO/YR \_\_\_\_\_\_\_\_  54. Panic attack? ……………………………………………………………………………………………..54. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, date of last panic attack? ……………..………………………………………… MO/ YR \_\_\_\_\_\_\_\_  55. Social anxiety disorder? …………………………………………………………………………………55. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, date of last occurrence of symptoms? ………………………………………… MO/ YR \_\_\_\_\_\_\_\_  56. Attention deficit/hyperactivity disorder (ADHD)? ..…………………………………………………….56. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, date of last occurrence of symptoms? ………………………………………… MO/ YR \_\_\_\_\_\_\_\_  57. Bipolar disorder? ………………………………………………………………………………………….57. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, did you ever have a manic episode?.............................................................. YES NO \_\_\_\_\_\_  58. Depressive disorder? ……………………………………………………………………………….……58. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, date of last occurrence of symptoms? ……..………………………………….. MO/ YR \_\_\_\_\_\_\_\_  59. Personality disorder? ………………………………………………………………………………….….59. YES \_\_\_\_\_ NO \_\_\_\_\_  60. Post-traumatic stress disorder (PTSD)? .……………………………………………………………….60. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, date of last occurrence of symptoms? …………..…………………………….. MO/ YR \_\_\_\_\_\_\_\_  61. Psychosis or psychotic features? ………………………………………………………………………. 61. YES \_\_\_\_\_ NO \_\_\_\_\_ | |
| **SECTION XI. (continued) Candidate Initials** \_\_\_\_\_\_ | |
| 62. Substance use disorder? …………………………………………………………………………………62. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, answer the questions below:   1. What substance(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Date of last use? …………………………………………………………... MO/YR \_\_\_\_\_\_\_\_\_\_\_\_\_ 3. Have you completed a substance use disorder treatment program?..…. YES \_\_\_\_\_ NO \_\_\_\_\_   63. Are you being treated for a mental health condition? ………………………………………………..63. YES NO \_\_\_\_\_  **If YES**, answer the questions below:   1. Are you treated by a psychologist or psychiatrist? ……………………… MO/YR \_\_\_\_\_\_\_\_\_ 2. Are you compliant with your treatment   (medications, follow-up appointments, referrals)? ……………………….. YES \_\_\_\_\_ NO \_\_\_\_\_   1. Do you have any sedating side effects from your treatment? .………….. YES \_\_\_\_\_ NO \_\_\_\_\_ 2. Do you have irritability? ….………………………………….………………. YES \_\_\_\_\_ NO \_\_\_\_\_ 3. Do you have difficulty concentrating? …………….….……………………. YES \_\_\_\_\_ NO \_\_\_\_\_ 4. Do you have any diagnosed phobias? …….………………………………. YES \_\_\_\_\_ NO \_\_\_\_\_ 5. Has your condition ever interfered with your job or daily activities?......... YES \_\_\_\_\_ NO \_\_\_\_\_   If **YES**, when was the last time your condition interfered with your job or activities? MO/YR  Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  64. Suicide attempt? ………………………………………………………………………………………….64. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, date: ………………………………………………………………………………….. MO/YR \_\_\_\_\_\_\_\_\_  65. Electroconvulsive therapy (ECT)? ………………………………………………………………………65. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, date of last ECT therapy: .………………………………………………………….. MO/YR \_\_\_\_\_\_\_\_\_  66. Schizophrenia, schizoaffective, or schizophreniform disorder? ……………………………………...66. YES \_\_\_\_\_ NO \_\_\_\_\_  67. Other mental health disorder not previously noted? ………………………………….……………….67. YES \_\_\_\_\_ NO \_\_\_\_\_  **If YES**, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     |  | | --- | | **EXAMINER COMMENTS – PSYCHOLOGICAL:** | | *Examiner MUST enter a comment on all positive history / “yes” answers.* | | |
| **SECTION XII. ACTIVITY** | |
| 68. Answer the questions below regarding your ability. Are you able to:  Frequently lift and carry passenger baggage weighing up to 50 pounds without assistance?...ABLE UNABLE \_\_\_\_\_\_\_  Frequently squat, bend and stoop?............................................................................................ABLE UNABLE \_\_\_\_\_\_\_  Frequently reach overhead with each arm? ..……………………………………………………….ABLE UNABLE \_\_\_\_\_\_\_  Stand continuously for up to 4 hours without a break? …………………………………………….ABLE UNABLE \_\_\_\_\_\_\_  Walk for up to 3 miles during a shift? ………………………………………………………………...ABLE UNABLE \_\_\_\_\_\_\_  Feel and manipulate small objects with both hands? ……..………………………………………..ABLE UNABLE \_\_\_\_\_\_\_  Open/close zippers, snaps, and buckles on baggage, backpacks, or briefcases? ……………..ABLE UNABLE \_\_\_\_\_\_\_ | |
| **SECTION XII. (continued)** | |
| **What is your present activity level?**  Circle the level of activity listed below that best describes how often you participate in each of the activities:   |  |  |  |  | | --- | --- | --- | --- | | **Activit y** | **Never/R arel y**  0 to 2 times per year | **Occasi onall y**  1 to 2 times per month | **Frequentl y**  Once per week or more | | Walk 2 miles continuously | Never/Rarely | Occasionall y | Frequentl y | | Run 2 miles continuously | Never/Rarely | Occasionall y | Frequentl y | | W eight training /general fitness activity at gym | Never/Rarely | Occasionall y | Frequentl y | | Team sports (basketball, football, soccer, etc.) | Never/Rarely | Occasionall y | Frequentl y | | Gardening / yard work | Never/Rarely | Occasionall y | Frequentl y | | Golf | Never/Rarely | Occasionall y | Frequentl y | | W inter sports (skiing, ice skating, etc.) | Never/Rarely | Occasionall y | Frequentl y | | Swimming / cycling | Never/Rarely | Occasionall y | Frequentl y | | Other (list): | Never/Rarely | Occasionall y | Frequentl y |   69. Do you have any restrictions or limitations on your activity or function? ………………………69. YES NO \_\_\_\_\_\_\_  **If YES**, explain in detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  70. Do you have anything additional to report that has not already been addressed? ……………70. YES NO \_\_\_\_\_\_\_  **If YES**, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | | **EXAMINER COMMENTS – ADDITIONAL COMMENTS:** | | *Examiner MUST enter a comment on all positive history / “yes” answers.* | | |
| **CANDIDATE SIGNS BELOW after reading the following statements:**  **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 have read the privacy statement at the beginning of this questionnaire and understand that falsification, misrepresentation or omission of information on Government forms is punishable by fine and/or imprisonment and/or may be grounds for disqualification from TSA employment, or disciplinary or adverse action if employed.  ***The exam information collected from your appointment for your TSO pre-placement physical will be forwarded to TSA’s primary medical contractor, Comprehensive Health Services (CHS). CHS is the sole authority for rendering TSO medical qualification determinations and they will contact you directly if they have any questions or need any further information to make an eligibility determination.***  REQUIRED Candidate Printed Name  Date (mm/dd/yyyy)  REQUIRED Candidate Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **FACILITY PROVIDER/EXAMINER (MD, DO, PA, or NP) SIGNS BELOW:**  REQUIRED Examiner Printed Name  Date (mm/dd/yyyy)  REQUIRED Examiner Signature  MD, DO, PA, NP (Circle one) | |
| **APPENDIX A** Candidate Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *If you have a history of Diabetes or Hypertension, complete the following for the purpose of calculating your ASCVD (atherosclerotic cardiovascular disease) risk score according to the American Heart Association and American College of Cardiology. This published formula requires the following information to calculate your ASCVD risk score per the TSO Medical Guidelines: current age, sex, race, systolic blood pressure, total cholesterol, HDL cholesterol, history of diabetes, smoking, and treatment for hypertension. If you know the following information, please circle the correct response and enter the values below:*  Race (circle one): White African American Other  Total Cholesterol (mg/dL): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approximate MO/YR \_\_\_\_\_\_\_\_\_\_ Don’t know \_\_\_\_\_\_\_\_\_\_\_  HDL Cholesterol (mg/dL): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approximate MO/YR \_\_\_\_\_\_\_\_\_\_ Don’t know \_\_\_\_\_\_\_\_\_\_\_  Smoker (circle one): Yes Former No | |

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| --- |
| **PUBLIC BURDEN STATEMENT:** TSA is collecting this information to determine your suitability to serve as a TSO. This is a voluntary collection of information; however, failure to furnish the requested information may result in an inability to consider your eligibility for employment as a TSO. TSA estimates that the total average burden per response associated with this collection is approximately1.65 hours, including the time for reviewing instructions, getting needed information, travel time to receive the necessary medical screening and reviewing the completed form. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing burden, to the U.S. Office of Personnel Management (OPM), Strategic Human Resources Policy, Medical Policy and Programs Division, Attn: OMB Number (1652-0032), 1900 E Street, NW, Washington, D.C. 20415. The control number assigned to this collection is OMB 1652-0032, which will expire on 7/31/2019. 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. |
| **PRIVACY ACT STATEMENT:** **AUTHORITY:** 49 U.S.C. 44935 PRINCIPAL PURPOSE(S): This information will be used to determine your eligibility for employment as a Transportation Security Officer (TSO). **ROUTINE USE(S):** This information may be shared with contractors, grantees, or volunteers performing or working on a contract, service, grant, cooperative agreement, or job for the federal government, or for routine uses identified in the Office of Personnel Management’s system of records notice, OPM/GOVT-10 Employee Medical File System Records (if hired) or OPM/GOVT-5 Recruiting, Examining, and Placement Records (if not hired). **DISCLOSURE:** Voluntary; failure to furnish the requested information may result in an inability to consider your application for employment. |

***Previous editions of this form are obsolete.***