



TRANSPORTATION SECURITY OFFICER MEDICAL QUESTIONNAIRE

PUBLIC BURDEN and PRIVACY ACT STATEMENTS

PUBLIC BURDEN STATEMENT: TSA is collecting this information to determine 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 approximately 1.65 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 OMB number control number assigned to this collection of information is 1652-0032, which will expire on 7/31/2023. 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.

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://jobs.tsa.gov/Resources/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

DEMOGRAPHIC INFORMATION

Name (Print): _____	Last 4 of Social Security #: <u>XXX - XX -</u>
Address: _____	Sex: Male _____ Female _____
City, State, Zip _____	
Primary Phone #: (____) _____	Date of Birth: _____
Secondary Phone #: (____) _____	(mm / dd / yyyy)
Other Phone#: _____	Height: Feet _____ Inches _____ Weight _____
Best Time to Call: _____	

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 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, physical therapist, healer, acupuncturist, or any other practitioner within the past year? 3. YES _____ NO _____

If YES, specify condition and healthcare provider consulted, and indicate date:

1. _____ MO/YR _____
2. _____ MO/YR _____
3. _____ MO/YR _____

GENERAL INFORMATION (continued)

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.

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:

a. Type of surgery: _____ Date: MO/YR _____

b. Do you have any dryness that affects your vision?..... YES ___ NO ___

c. 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.

RESPIRATORY

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:

a. When was your last Chest X-Ray?..... Date: MO/YR_____

b. When were you treated?..... Date: MO/YR_____

c. 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.

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:**

a. 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 ____

b. 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:

a. Indicate MO/YR or Not applicable (NA):

Heart attack _____ Open heart surgery _____ Stent or angioplasty _____

b. 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 ____

c. Do you have chest pain with exertion or activity? YES ____ NO ____

d. Are your risk factors being treated (smoking, hypertension, cholesterol, obesity, etc.)? YES ____ NO ____

e. When was your last heart medication change? MO/YR_____

f. Have you been compliant with treatment? YES ____ NO ____

CARDIOVASCULAR (continued)

16. Heart failure? 16. YES ___ NO ___

If YES, answer the question below:

a. 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:

a. Did you have an ablation? YES ___ NO ___

Date(s) of ablation? MO/YR _____

Was it successful? YES ___ NO ___

b. Have you had an echocardiogram, or stress echocardiogram? YES ___ NO ___

If YES, indicate the ejection fraction if known: % Don't know ___

c. 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:

ABDOMINAL ORGANS and RENAL

27. Have you had or do you currently have a hernia? 27. YES ____ NO ____

If YES, answer questions below:

- a. Circle type: inguinal ventral umbilical femoral
- b. Has it been repaired? YES ____ NO ____
- c. 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.

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:

- a. Specify body part: _____
- b. 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.

NEUROLOGICAL

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:

a. Specify type and date: _____ MO/YR _____

b. 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:

a. Do you have epilepsy?..... YES ____ NO ____

b. What causes your seizures? _____ Don't Know _____

c. Date of last seizure? MO/YR _____

d. 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:

a. Specify date of diagnosis: MO/YR _____

b. Specify date of last relapse: MO/YR _____

c. 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.

ENDOCRINE

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:**

- a. Are you compliant with your prescribed treatment?YES ____NO ____
- b. 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. _____

- c. Have you had diabetic ketoacidosis in the past 12 months? YES ____NO ____
- d. What was your last hemoglobin A1c? ... _____ % Don't know _____
- e. When was your last hemoglobin A1c? MO/YR _____
- f. Have you completed diabetes education? YES ____NO ____
- g. Do you self-monitor your blood glucose? YES ____NO ____
- h. Do you have lightheadedness with standing? YES ____NO ____
- i. Do you have peripheral neuropathy that interferes with your activity? ... YES ____NO ____

If YES, explain: _____

- j. Do you have chronic kidney disease (CKD)? YES ____NO ____
- If YES**, specify GFR _____mL/min Don't know _____

- k. Have you had a dilated eye exam?YES ____NO ____
- If YES**, specify last exam date:..... MO/YR _____

- l. Do you have retinopathy? YES ____NO ____

- m. 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 ____

- n. 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 ____

- o. 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.

SLEEP DISORDERS

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:

a. 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 _____

b. 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.

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 _____

PSYCHOLOGICAL (continued)

61. Psychosis or psychotic features? 61. YES _____ NO _____

62. Substance use disorder? 62. YES _____ NO _____

If YES, answer the questions below:

a. What substance(s)? _____

b. Date of last use? MO/YR _____

c. 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:

a. Are you treated by a psychologist or psychiatrist? YES _____ NO _____

If YES, when was your last visit?.....MO/YR _____

b. Are you compliant with your treatment (medications, follow-up appointments, referrals)?YES _____ NO _____

Date of last treatment MO/YR _____

c. Do you have any sedating side effects from your treatment?YES _____ NO _____

d. Do you have irritability?YES _____ NO _____

e. Do you have difficulty concentrating?YES _____ NO _____

f. Do you have any diagnosed phobias?YES _____ NO _____

g. 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? 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.

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 _____

ACTIVITY (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:

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 /general fitness activity at gym	Never/Rarely	Occasionally	Frequently
Team sports (basketball, football, soccer, etc.)	Never/Rarely	Occasionally	Frequently
Gardening / yard work	Never/Rarely	Occasionally	Frequently
Golf	Never/Rarely	Occasionally	Frequently
Winter sports (skiing, ice skating, etc.)	Never/Rarely	Occasionally	Frequently
Swimming / cycling	Never/Rarely	Occasionally	Frequently
Other (list):	Never/Rarely	Occasionally	Frequently

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, Acuity-Comprehensive Health Services (CHS). Acuity-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

How long ago did you quit?

Previous editions of this form are obsolete.