OMB No. 1652-0032
Exp. 7/31/2023

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):

Address:

City, State, Zip

Last 4 of Social Security #: XXX - XX - _____

Sex: Male _____ **Female** _____

Primary Phone #: (_____) _____

Secondary Phone #: (_____) _____

Other Phone#: _____

Best Time to Call:

Date of Birth:
(mm / dd / yyyy)

Height: Feet _____ **Inches** _____ **Weight** _____

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)

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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.