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| Part A. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | DOB: |  |
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| Questions | Yes | No |
| Has there been a new psychological diagnosis in the last year, e.g. depression, anxiety, bipolar disorder, ADD, etc.? |  |  |
| Have you had an amputation or prosthesis, transplant or implant occur in the last year? |  |  |
| Any new prescribed medications or over the counter medications that you take on a fairly regular basis in the last year? |  |  |
| Any new immune or infectious problems or any new allergies in the last year? |  |  |
| Any change in your vision or problems with your eyes or eyelids in the last year? |  |  |
| Any new problems with your head or neck, ears, nose, mouth, or throat in the last year? |  |  |
| Any new problems with hearing in the last year? |  |  |
| Any new endocrine or metabolic issues your medical provider has evaluated you for in the last year, eg. thyroid, adrenal, pituitary, diabetes? |  |  |
| Any new skin issues you have been treated for in the last year? |  |  |
| Any new vein or artery problems in the last year? |  |  |
| Any new heart problems or diagnosis of high blood pressure in the last year? |  |  |
| Any new lung problems or diagnosis of sleep apnea in the last year? |  |  |
| If you are female, are you pregnant? |  |  |
| Any blood or spleen problems in the last year? |  |  |
| Any muscle problems, spine problems, new herniated/bulging disc, pinched nerves, arthritis, arm or leg injury, compartment syndrome, or other problems in the last year? |  |  |
| Any new neurologic problems e.g. headaches, dizziness, seizures, Parkinson's disease, stroke, problem staying awake routinely, problem with taste or smell or touch in the last year? |  |  |
| Any stomach, liver, pancreas, intestinal/colon or hernia problems in the last year? |  |  |
| Any kidney, bladder, ovary, testicle, prostate problems or severe menstrual cramp problems in the last year? |  |  |
| Any new heat illness, heat exhaustion, heat stroke, or rhabdomyolysis in the last year? |  |  |
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| **Signature** |  |  |
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| **Home Unit and Forest Name:** |  |  |
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| **Home Unit Address:** |  |  |
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| Part B. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | DOB: |  |
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| BP: |  |  |
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| **signature of person taking BP** |  |  |
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| **printed name and title (N.P., P.A., EMT, RN, etc.) of person taking BP and phone number**  Medical Review Officer to complete:  \_\_\_Medically Qualified  \_\_\_Need more information  \_\_\_Not Medically Qualified  Sign\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_ |  |  |
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