JSC FORM 1830 - REPORT OF MEDICAL EXAMINATION

Form Approved
O.M.B.
No. 2700-0170
Expires: xx/xx/xxxx

Applicant Must Complete This Page
PLEASE TYPE OR PRINT CLEARLY IN DARK INK

1. Application For:	2. Last Name	First Name	Middle Name

3. E-mail	Telephone: Work: Other:

4. Street Address	City	State	Zip

5. DOB(M/D/Y)	6. Sex	7. Hair Color	8. Eyes Color	9. Type: ☐ NASA : ☐ Federal Employee ☐ Commercial Other ____	10. Employer:

11. Do you Currently Use Any Medication (Prescription or Nonprescription)? ☐ Yes ☐ No
If yes, give name, purpose, dosage, and frequency.

12. Medical History - Have you ever had or do you now have any of the following? Answer "yes" for every condition you have ever had in your life. Describe the condition and the approximate date of occurrence in the explanation box provided below.

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
a. ☐	☐	Frequent or severe headaches	i. ☐	☐	Stomach, liver, or intestinal trouble	q. ☐	☐	Motion sickness requiring medication
b. ☐	☐	Dizziness or fainting spell	j. ☐	☐	Kidney stone or blood in urine	r. ☐	☐	Military medical discharge
c. ☐	☐	Unconsciousness for any reason	k. ☐	☐	Diabetes	s. ☐	☐	Medical rejection by military service
d. ☐	☐	Eye or vision trouble (except glasses)	l. ☐	☐	Neurological disorders; epliepsy, seizures, stroke, paralysis, etc.	t. ☐	☐	Rejection for life or health insurance
e. ☐	☐	Hay fever or allergy	m. ☐	☐	Mental disorders of any sort depression, anxiety, etc.	u. ☐	☐	Admission to hospital
f. ☐	☐	Asthma or lung disease	n. ☐	☐	Substance dependence or failed a drug test (ever), or substance abuse or use of illegal substance in the last five years	v. ☐	☐	Other illness, disability, or surgery
g. ☐	☐	Heart or vascular trouble	o. ☐	☐	Alcohol dependence or abuse			
h. ☐	☐	High or low blood pressure	p. ☐	☐	Suicide attempt			

12 A. Explanations: If you answered YES to any of the above items, describe the condition and the approximate date of occurrence. Use additional page if needed.

13. Visits to Health Professional Within Last 3 Years. ☐ Yes (explain below) ☐ No

Date	Name, Address, and Type of Health Professional Consulted	Reason For Visit

NOTE: I declare under penalty of perjury that I have examined all the information on this form, and on the accompanying physician form, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

14. Signature of Applicant	15. Date

"CUI//SP-HLTH when filled in"

Examiner Must Complete and Sign This Page
Please Type or Print Clearly In Dark Ink

CHECK EACH ITEM IN APPR. COLUMN	Normal	Abnormal	CHECK EACH ITEM IN APPR. COLUMN	Normal	Abnormal
16. Head, face, neck, and scalp	☐	☐	28. Vascular system (Pulse, amplitude and character, arms, legs, others)	☐	☐
17. Nose	☐	☐	29. Abdomen and viscera (Including hernia)	☐	☐
18. Sinuses	☐	☐	30. Anus (Not including digital examination)	☐	☐
19. Mouth and throat	☐	☐	31. Skin	☐	☐
20. Ears, general (internal and external canals: Hearing under item 49)	☐	☐	32. G-U system (Not including pelvic examination)	☐	☐
21. Ear Drums (Perforation)	☐	☐	33. Upper and lower extremities (Strength and range of motion)	☐	☐
22. Eyes, general (Vision under items 50 to 54)	☐	☐	34. Spine, other musculoskeletal	☐	☐
23. Ophthalmoscopic	☐	☐	35. Identifying body marks, scars, tattoos (Size & location)	☐	☐
24. Pupils (Equality and reaction)	☐	☐	36. Lymphatics	☐	☐
25. Ocular motility (Associated parallel movement, nystagmus)	☐	☐	37. Neurologic (Tendon reflexes, equilibrium, senses, cranial nerves, coordination, etc.)	☐	☐
26. Lungs and chest (Not including breasts examination)	☐	☐	38. Psychiatric (Appearance, behavior, mood, communication, and memory)	☐	☐
27. Heart (Precordial activity, rhythm, sounds, and murmurs)	☐	☐	39. General systemic	☐	☐

NOTES: Describe any above items checked "**Abnormal**" in detail. Enter item number before each comment. Use additional sheets if necessary.

40. Height	41. Weight	42. Hearing	Voice Test		Audiometer Threshold in Decibels									
			Right Ear	Left Ear	Right Ear					Left Ear				
					500	1000	2000	3000	4000	500	1000	2000	3000	4000

43. Distant Vision			44. Near Vision			45. Color Vision
Right	20/	Corrected	Right	20/	Corrected to 20/	☐ Normal
Left	20/	Corrected	Left	20/	Corrected to 20/	☐ Abnormal
Both	20/	Corrected	Both	20/	Corrected to 20/	

46. Field of Vision	47. Heterophoria 20' (in prism diopters)			
☐ Normal ☐ Abnormal	Esophoria	Exophoria	Right Hyperphoria	Left Hyperphoria

48. Blood Pressure (sitting mm of Mercury)		49. Pulse (Resting)	50. Urinalysis ☐Normal ☐Abnormal (give results)		51. EKG (Date)		
Systolic	Diastolic		Albumin	Sugar	MM	DD	YY

52. Other Tests Given	EKG Results:

53. Significant Medical History ☐ Yes ☐ No Abnormal Physical Findings ☐ Yes ☐ No
Physician shall elaborate on all pertinent data; comment on all "YES" answers in the Medical History (pg 1, #12) and any abnormal findings of the exam. Physician may develop, by interview, any additional medical history deemed important, and record any significant findings here. ATTACH ADDITIONAL COMMENTS ON HISTORY & FINDINGS.

54. Applicant's Name	55. Disqualifying Defects (List by item number)

56. Medical Examiner's Declaration - I hereby certify that I have personally reviewed the medical history and personaly examined the applicant named on this medical examination report. This report, with any attachment, embodies my findings completely and correctly.

Exam Date			57. PHYSICIAN'S FULL NAME / ADDRESS / CITY / STATE / ZIP
MM	DD	YY	

Physician's Signature	Physician Telephone
	( )

PRIVACY ACT STATEMENT

Pursuant to the Privacy Act of 1974 (5 U.S.C. § 552a), the following statement is provided to individuals supplying information for inclusion in the NASA Health Information Management System.

AUTHORITY: The collection of this information is authorized by 5 USC §7901; 51 U.S.C. § 20113(a); 44 U.S.C. §3101; and 42 CFR Part 2.

PURPOSE: Information in this system of records is maintained on individuals receiving health care or health clearance through a NASA clinic or healthcare activity. The information will be used to assess the health of potential divers seeking clearance for use of NASA's Neutral Buoyancy Laboratory. This information becomes part of NASA's Health Information Management System.

ROUTINE USES: Records collected through this form may be disclosed as described in the System of Records Notice "Health Information Management System, NASA 10HIMS," available at: https://www.federalregister.gov/documents/2023/10/10/2023-22412/privacy-act-of-1974-system-of-records.

DISCLOSURE: Failure to provide the requested information may result in denial of NASA facility use.

PAPERWORK REDUCTION ACT STATEMENT

The public burden to complete this information collection is estimated at 90 minutes per response, including time for reviewing instructions, searching data sources, gathering and maintaining data needed, and completing and reviewing the collected information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to jsc-nbl-guest-diver-@mail.nasa.gov. Current information regarding this collection of information - including all background materials - can be found at https:/www.reginfo.gov/public/do/PRAMain using the search function to enter either the title of the collection or 2700-0170.