

NATIONAL SCIENCE FOUNDATION - POLAR PHYSICAL EXAMINATION

**MEDICAL HISTORY**

<p><i>Complete pages 1-5 in ink prior to Dr.'s exam</i></p>	<p><b>Polar Medical Staff Use Only</b></p> <p>Date: _____ <input type="checkbox"/> PQ <input type="checkbox"/> PQ Summer Only <input type="checkbox"/> NPQ</p> <p>Medical Condition(s):</p> <p>_____</p> <p>_____</p>			
<p><b>Polar Medical Staff Use Only</b></p> <p>Reviewed by: _____</p> <p>Date: _____</p>	<p><b>Restrictions and Follow-up:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Reason for NPQ:</b></p> <p>_____</p> <p>_____</p>			
Name: last, first, middle (must match passport)		Age:	Birth date (MM/DD/YY):	Sex: <input type="checkbox"/> F <input type="checkbox"/> M
Nickname (aka)		Maiden Name:	Previous Name or Other Legal Name:	
Street		City	State	Zip
Telephone (include area code):				
Day:	Evening:	Mobile:	E-Mail:	
Emergency Point of Contact (Name, Address and Phone Number):				
<b>Job Title:</b>	Current Deployment Dates: From _____ to _____		Previous Polar (Arctic or Antarctic) Deployment? Dates: _____ Location: _____	
<b>Affiliation:</b> <input type="checkbox"/> NSF <input type="checkbox"/> Science Event # _____ <input type="checkbox"/> Technical Event # _____ <input type="checkbox"/> RPSC <input type="checkbox"/> CH2M HILL <input type="checkbox"/> Other: _____		<b>Proposed Antarctic Season and Worksite:</b> <input type="checkbox"/> Summer (Sep-Feb) <input type="checkbox"/> Winter (Mar-Oct) <input type="checkbox"/> Winfly _____ (dates) <input type="checkbox"/> McMurdo Station <input type="checkbox"/> South Pole Station <input type="checkbox"/> Palmer Station <input type="checkbox"/> RV/NB Palmer <input type="checkbox"/> RV/LM Gould <input type="checkbox"/> Field Camp _____ <input type="checkbox"/> Other (specify): _____		<b>Proposed Arctic Season and Worksite:</b> <input type="checkbox"/> Summer (Mar-Sep) <input type="checkbox"/> Winter (Oct-Feb) <input type="checkbox"/> Summit <input type="checkbox"/> USCGC Healy <input type="checkbox"/> Field Camp _____ <input type="checkbox"/> Other: _____

NAME \_\_\_\_\_

DOB \_\_\_\_\_

CURRENT MEDICATIONS						
Name	Dose	Frequency		Name	Dose	Frequency

ALLERGIES			
Name	TYPE OF REACTION		TYPE OF REACTION

PAST HOSPITALIZATIONS			
Condition	Date	Condition	Date

PAST SURGERIES			
Condition	Date	Condition	Date

MEDICAL TESTING/PROCEDURES IN PREVIOUS 3 YEARS		
Type (specify body location)	Date	Describe: reason for test procedure and result
MRI		
CT		
Ultrasound		
Angiogram		
Biopsy		
Other		

IMMUNIZATION HISTORY			
	Date – most recent immunization		Dates of immunization
Influenza		Hepatitis A	
DT		Hepatitis B	
DPT		Other (specify)	
Pneumococcus			

NAME \_\_\_\_\_

DOB \_\_\_\_\_

<b>SOCIAL HISTORY</b>							
<b>Tobacco</b>		<b>yes</b>	<b>no</b>	Describe: Packs/week    Total yrs.    Year last			
Do you currently use tobacco products?							
Have you used tobacco products in the past?							
<b>Alcohol</b>		<b>yes</b>	<b>no</b>				
Do you drink alcohol?							
If abstinent, please enter date of your last alcoholic beverage:							
Have you ever felt you should decrease your alcohol consumption?				Describe:			
Have you ever received a DUI, DWAI or court ordered treatment for alcohol?							
Have you been diagnosed as an alcoholic?							
<b>Exercise and conditioning</b>		<b>yes</b>	<b>no</b>	Describe:			
Do you have a regular exercise program?				Date of last treadmill:			
Have you had a cardiovascular stress test?							
<b>GENERAL MEDICAL HISTORY</b>							
<b>ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY</b>							
<i>Condition</i>		<i>Yes</i>	<i>No</i>	<i>Condition</i>		<i>Yes</i>	<i>No</i>
<b>1</b>	<b>Neurology</b>			2D	Congestive heart failure		
1A	Cerebrovascular accident (CVA)			2E	Coronary angioplasty/stent/bypass		
1B	Concussion			2F	Coronary artery disease		
1C	Dizziness/Loss of Consciousness			2G	Heart murmur/valvular heart disease		
1D	Headaches (Migraine)			2H	Hypertension (high blood pressure)		
1E	Headaches (Other)			2I	Myocardial Infarction (MI)		
1F	Multiple sclerosis			2J	Supraventricular tachycardia (SVT)		
1G	Peripheral neuropathy			2K	Other cardiac condition		
1H	Seizures			<b>3</b>	<b>Vascular disease</b>		
1I	Transient ischemic attack (TIA)			3A	Abdominal aneurysm		
1J	Traumatic brain injury (TBI)			3B	Arterial emboli		
1K	Other neurological disorder			3C	Cerebral aneurysm		
<b>2</b>	<b>Cardiology</b>			3D	Deep venous thrombosis (DVT)		
2A	Angina/chest pain			3E	Venous stasis ulcers		
2B	Atrial fibrillation			3F	Other vascular condition		
2C	Cardiac pacemaker/defibrillator						
<p><i>For all "yes" answers, please provide details to include age of onset, frequency of event, date of last episode, current medications, other therapies and status of the condition.</i></p>							

NAME \_\_\_\_\_

DOB \_\_\_\_\_

GENERAL MEDICAL HISTORY						
ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY						
Condition		Yes	No	Condition		No
<b>4</b>	<b>Rheumatologic disease</b>			8L	Peptic ulcer disease	
4A	Fibromyalgia			8M	Ulcerative colitis	
4B	Osteoarthritis			8N	Other gastrointestinal disease	
4C	Rheumatoid arthritis			<b>9</b>	<b>Dermatology</b>	
4D	Systemic Lupus erythematosus			9A	Dermatitis	
4E	Other rheumatologic condition			9B	Melanoma	
<b>5</b>	<b>Ears Nose and Throat</b>			9C	Psoriasis/Eczema	
5A	Hearing impairment			9D	Skin cancer	
5B	Nosebleeds			9E	Other skin condition	
5C	Seasonal Allergies			<b>10</b>	<b>Orthopedic</b>	
<b>6</b>	<b>Ophthalmology</b>			10A	Cervical spine injury	
6A	Glaucoma			10B	Chronic pain	
6B	Visual impairment			10C	Dislocation	
6C	Other eye condition			10D	Fractures	
<b>7</b>	<b>Pulmonary</b>			10E	Low back injury	
7A	Altitude sickness			10F	Orthopedic pins/plates	
7B	Asthma			10G	Other orthopedic condition	
7C	Chronic bronchitis/bronchiectasis			<b>11</b>	<b>Metabolic</b>	
7D	Chronic obstructive pulmonary disease			11A	Adrenal insufficiency	
7E	Dyspnea (shortness of breath)			11B	Diabetes Type I	
7F	Obstructive sleep apnea			11C	Diabetes Type II	
7G	Pulmonary embolism			11D	Gout	
7H	BCG Vaccine or Positive TB Test			11E	Hypercholesterolemia	
7I	Other pulmonary condition			11F	Hyperthyroidism	
<b>8</b>	<b>Gastrointestinal disease</b>			11G	Hypothyroidism	
8A	Black tarry stools			11H	Pituitary insufficiency	
8B	Blood in stool			11I	Other hormonal disorder	
8C	Cholelithiasis (gallstones)			<b>12</b>	<b>Gynecology-female</b>	
8D	Crohn's disease			12A	Menstrual period in past 30 days	
8E	Frequent or persistent diarrhea			12B	Date of last PAP smear	
8F	Gastroesophageal reflux (GERD)			12C	Premenstrual syndrome (PMS)	
8G	Hemorrhoids			12D	Endometriosis	
8H	Hepatitis (describe type)			12E	Severe menstrual cramps	
8I	Hernia			12F	Ovarian cysts	
8J	Irritable bowel syndrome (IBS)			12G	Sexually transmitted disease	
8K	Pancreatitis			12H	Other gynecological conditions	

*For all "yes" answers, please provide details to include age of onset, frequency of event, date of last episode, current medications, other therapies and status of the condition.*

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**GENERAL MEDICAL HISTORY**

**ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY**

<i>Condition</i>		<i>Yes</i>	<i>No</i>	<i>Condition</i>		<i>Yes</i>	<i>No</i>
<b>13</b>	<b>Psychiatric</b>			<b>15</b>	<b>Hematology/Oncology</b>		
13A	Addiction			15A	Anemia		
13B	Anxiety/panic attacks			15B	Cancer (describe type)		
13C	Attention deficit disorder			15C	Leukemia		
13D	Bipolar			15D	Lymphoma - Hodgkins		
13E	Depression			15E	Lymphoma – non Hodgkins		
13F	Eating disorder (bulimia/anorexia)			15F	Platelet disorder		
13G	Hospitalization for psych condition			15G	Other hematologic/oncologic		
13H	Post traumatic stress disorder			<b>16</b>	<b>Genitourinary - male</b>		
13I	Schizophrenia			16A	Prostate disease		
13J	Suicidal thoughts or attempts			16B	Sexually transmitted disease		
13K	Other psychiatric condition			16C	Testicular abnormality		
<b>14</b>	<b>Renal disease</b>			16D	Other genitourinary condition		
14A	Chronic Renal Disease						
14B	Frequent urinary tract infections						
14C	Hematuria (blood in urine)						
14D	Kidney stones						
14E	Other kidney condition						

*For all “yes” answers, please provide details to include age of onset, frequency of event, date of last episode, current medications, other therapies and status of the condition.*

*I certify that the information contained herein is complete and accurate to the best of my knowledge. I will inform the contractor’s medical staff of ALL medical/health changes, including medications that occur after submitting this form. I understand that failure to provide any or all of the requested information may result in a denial of my application for assignment to the Polar regions. I also understand that willfully providing false statements to a Federal agency or its representatives is a criminal offense.*

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date