NATIONAL SCIENCE FOUNDATION - POLAR PHYSICAL EXAMINATION

MEDICAL HISTORY

Complete pages 1-5 in ink prior to Dr.'s exam	***Polar Medical Staff Use Only*** *Date:* ______________ ☐ *PQ* ☐ *PQ Summer Only* ☐ *NPQ* *Medical Condition(s):*
Polar Medical Staff Use Only Reviewed by:_________ Date: _______________	*Restrictions and Follow-up:* ____________________ ____________________ *Reason for NPQ:* ____________________ ____________________

Name: last, first, middle (must match passport)	Age:	Birth date (MM/DD/YY):	Sex: ☐ F ☐ 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):

Job Title:	Current Deployment Dates: From ______________ to _______________	Previous Polar (Arctic or Antarctic) Deployment? Dates: __________________ Location: _________________________

Affiliation: ☐ NSF	**Proposed Antarctic Season and Worksite**:	**Proposed Arctic Season and Worksite**:
☐ Science Event #_______	☐ Summer (Sep-Feb)	☐ Summer (Mar-Sep)
☐ Technical Event #______	☐ Winter (Mar-Oct)	☐ Winter (Oct-Feb)
☐ ASC (________________)	☐ Winfly ________________ (dates)	☐ Summit
☐ CH2M HILL	☐ McMurdo Station	☐ USCGC Healy
☐ Other:_________________	☐ South Pole Station	☐ Field Camp ________________________________
	☐ Palmer Station	☐ Other:____________________________________
	☐ RV/NB Palmer	
	☐ RV/LM Gould	
	☐ Field Camp ______________	
	☐ Other (specify): ______________________________	

NAME________________________________ DOB _______________________

CURRENT MEDICATIONS						
Name	**Dose**	**Frequency**		**Name**	**Dose**	**Frequency**

ALLERGIES				
Name	**TYPE OF REACTION**		**Name**	**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				

SOCIAL HISTORY			
Tobacco	**yes**	**no**	Describe: Packs/week Total yrs. Year last
Do you currently use tobacco products?			
Have you used tobacco products in the past?			
Alcohol			Describe:
Do you drink alcohol?			
If abstinent, please enter date of your last alcoholic beverage:			

NAME________________________________ DOB ______________________

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?			
Exercise and conditioning	**yes**	**no**	Describe:
Do you have a regular exercise program?			
Have you had a cardiovascular stress test?			Date of last treadmill:

GENERAL MEDICAL HISTORY

New Government regulations require that we inform you of the following:

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Therefore, you should not forward any information related to your family's medical history and only submit answers to these questions regarding your own personal/individual history.

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY

	Condition	*Yes*	*No*		*Condition*	*Yes*	*No*
1	**Neurology**			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			**3**	**Vascular disease**		
1I	Transient ischemic attack (TIA)			3A	Abdominal aneurysm		
1J	Traumatic brain injury (TBI)			3B	Arterial emboli		
1K	Other neurological disorder			3C	Cerebral aneurysm		
2	**Cardiology**			3D	Deep venous thrombosis (DVT)		
2A	Angina/chest pain			3E	Venous stasis ulcers		
2B	Atrial fibrillation			3F	Other vascular condition		
2C	Cardiac pacemaker/defibrillator						

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.

NAME______________________________ DOB ______________________

GENERAL MEDICAL HISTORY

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY

	Condition	*Yes*	*No*		*Condition*	*Yes*	*No*
4	**Rheumatologic disease**			8L	Peptic ulcer disease		
4A	Fibromyalgia			8M	Ulcerative colitis		
4B	Osteoarthritis			8N	Other gastrointestinal disease		
4C	Rheumatoid arthritis			**9**	**Dermatology**		
4D	Systemic Lupus erythematosis			9A	Dermatitis		
4E	Other rheumatologic condition			9B	Melanoma		
5	**Ears Nose and Throat**			9C	Psoriasis/Eczema		
5A	Hearing impairment			9D	Skin cancer		
5B	Nosebleeds			9E	Other skin condition		
5C	Seasonal Allergies			**10**	**Orthopedic**		
6	**Ophthamology**			10A	Cervical spine injury		
6A	Glaucoma			10B	Chronic pain		
6B	Visual impairment			10C	Dislocation		
6C	Other eye condition			10D	Fractures		
7	**Pulmonary**			10E	Low back injury		
7A	Altitude sickness			10F	Orthopedic pins/plates		
7B	Asthma			10G	Other orthopedic condition		
7C	Chronic bronchitis/bronchiectasis			**11**	**Metabolic**		
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		
8	**Gastrointestinal disease**			11G	Hypothyoidism		
8A	Black tarry stools			11H	Pituitary insufficiency		
8B	Blood in stool			11I	Other hormonal disorder		
8C	Cholelithiasis (gallstones)			**12**	**Gynecology-female**		
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.

NAME_______________________________ DOB ______________________

GENERAL MEDICAL HISTORY

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY

Condition		Yes	No	Condition		Yes	No
13	**Psychiatric**			**15**	**Hematology/Oncology**		
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			**16**	**Genitourinary - male**		
13I	Schizophrenia			16A	Prostate disease		
13J	Suicidal thoughts or attempts			16B	Sexually transmitted disease		
13K	Other psychiatric condition			16C	Testicular abnormality		
14	**Renal disease**			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***