DEPARTMENT OF HOMELAND SECURITY

U.S. Coast Guard

OCCUPATIONAL MEDICAL HISTORY AND EXAMINATION FORM

Privacy Act Statement

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PART 1 - IDENTIFICATION

Employee Last Name, First Name, Middle Initial	Date of Exam	Sex *(Male or Female)*	Date of Birth

Unit Name & Location *(city, state)*	Occupation/Job Series

Work/Duty Phone	Home Address

Home/Cell Telephone *(Applicant)*	Personal E-mail Address *(Applicant)*

XO/XPO E-mail Address *(Required)*	CO E-mail Address *(Required)*

PART 2 - EXAMINATION TYPE AND EXPOSURES

To be filled out by the CG Unit OMSEP Coordinator OR Medical Officer/Healthcare Provider

EXAMINATION TYPE

☐ Baseline ☐ Periodic ☐ End of Exposure ☐ End of Employment ☐ Acute Exposure

If there are multiple exposure protocols which are not the same examination type, provide details here:

SURVEILLANCE PROTOCOLS FOR THIS EXAMINATION *(Occupational Noise does NOT require this form. Respirator Use Protocol requires this form only if a physical examination is needed.)*

☐ Respirator Use	☐ Respiratory Sensitizers	☐ Herbicides
☐ Hazardous Waste/Emergency Response	☐ Chromium Compounds	☐ Asbestos *(Current)*
☐ Benzene	☐ Ionizing Radiation	☐ Asbestos *(Past)*
☐ Lead	☐ Class 3B and 4 Lasers	☐ Cadmium
☐ Solvents *(Other than Benzene)*	☐ Pesticides Organphosphates/Carbamates	

PART 3 - *PAST* OCCUPATIONAL HISTORY

(Only for Preplacement or Baseline* Examination*)

Agency/Company	Dates of Employment (from - to)	Job Duties	Specific Hazards*

** such as asbestos, lead, chromium, cadmium, cobalt, beryllium, fumes, radiation, vibration, loud noise*

PART 4 - CURRENT AND PAST NON-OCCUPATIONAL EXPOSURES

	YES	NO
1. Lead exposure from making ceramics or stained glass and guns/hunting?	☐	☐
2. Noise exposure in the form of guns/hunting, motorcycles, loud music?	☐	☐
3. Solvent exposure?	☐	☐
4. Radiation exposure?	☐	☐

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PART 5 - SOCIAL AND MEDICAL HISTORY

A. MEDICATIONS: ☐ **NONE**

If only occasional use, indicate how often

B. SOCIAL HISTORY

Have you ever used tobacco? ☐ Yes ☐ No

Tobacco type? ☐ Cigarettes ☐ Pipe/Cigar ☐ Snuff/Chewing

Do you currently use tobacco? ☐ Yes ☐ No

Have you smoked any cigarettes in the past month? ☐ Yes ☐ No

Number of years that you have smoked cigarettes: _____

Average number of packs per day you have smoked: _____

Average alcohol consumption in a week? _____drinks

(1 drink = 12 oz. beer, 5 oz. wine or 1.5 oz. liquor)

C. ALLERGIES TO MEDICATIONS, LATEX, BEES, etc.

D. USE OF MEDICAL EQUIPMENT: ☐ **NONE** *(e.g., Eyeglasses [type], contact lenses [type], CPAP, hearing aid, brace)*

List here

E. HOSPITALIZATIONS AND SURGERIES: ☐ **NONE**

Year	Reason for hospitalization and type of surgery *(If within last 12 months, provide month and year)*

PART 6 - MEDICAL HISTORY

Which of the following conditions have you **EVER HAD**? ☐ **NONE**

(If year of diagnosis known, write in space before medical condition; if year unknown place an "X" in space before medical condition.)

	Anemia		Emphysema		Kidney disease/stones/Blood in urine
	Arthritis		Eye disorder/Lazy eye		Loss/Near loss of consciousness
	Asthma		Gallbladder/Liver disease		Mental health/Emotional disorder
	Cancer: _____		Head Injury		Migraines
	Car/sea/air sickness		Heart arrhythmia		Positive TB skin/blood test
	Chest/Heart surgery		Heart attack		Prostate problem
	Chronic bronchitis		Heart disease		PTSD
	Claustrophobia		Heart murmur		Seizure
	Collapsed lung		Heat cramps/exhaustion		Skin disease/Eczema
	Color blindness		Hemorrhoids		Sleep apnea
	Depression/Anxiety		Hepatitis		Stomach disorder/Frequent or severe heartburn
	Diabetes		Hernia/Rupture		Stroke or Mini-stroke (TIA)
	Dizziness/Vertigo		Herniated disc		Use of hearing aid
	Endocrine disorder of adrenal, parathyroid, thyroid		High blood pressure		Vascular disease

Comments regarding positive medical history

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PART 7 - REVIEW OF SYSTEMS

Which of the following have you **HAD IN THE PAST YEAR?** ☐ **NONE**

General/Constitutional

- ☐ Generalized weakness
- ☐ Unexplained weight loss
- ☐ Excessive fatigue
- ☐ Swollen glands
- ☐ Loss of appetite

Digestive System

- ☐ Nausea/vomiting/diarrhea
- ☐ Frequent or severe heartburn
- ☐ Jaundice
- ☐ Rectal bleeding/black stool/blood in stool

Genitourinary/Reproductive

- ☐ Difficult or painful urination
- ☐ Blood in urine
- ☐ Difficulty having children, miscarriage, stillbirth ☐ N/A

Eyes/Ears, Nose, Throat

- ☐ Change in vision
- ☐ Itching/tearing of eyes
- ☐ Difficulty hearing
- ☐ Ringing/buzzing
- ☐ Sinus trouble
- ☐ Nasal congestion
- ☐ Sneezing/runny nose
- ☐ Nosebleeds
- ☐ Difficulty swallowing
- ☐ Severe tooth or gum trouble

Neurologic/Psychiatric

- ☐ Headaches
- ☐ Dizziness
- ☐ Problems with balance
- ☐ Numbness/tingling
- ☐ Depression
- ☐ Excessive anxiety
- ☐ Personality or behavior change
- ☐ Insomnia/difficulty sleeping/snoring
- ☐ Loss of memory

Men Only

- ☐ Lump in testicle

Women Only

- ☐ Miscarriage/stillborn pregnancy
- ☐ Breast lump
- ☐ Currently or possibly pregnant

Heart/Lungs

- ☐ Chest pain/pressure
- ☐ Irregular heart beat
- ☐ New or changed cough
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Shortness of breath

Skin/Musculoskeletal

- ☐ Skin rash/ulcer/infection/boil
- ☐ Muscle pain
- ☐ Back pain
- ☐ Neck pain
- ☐ Weakness in arms/legs
- ☐ Joint pain *(which joints, how severe, what activities are difficult?)*

Comments regarding positive symptoms

I certify that all of the information I have provided on this form is complete and accurate to the best of my knowledge, and that submitting information that is incomplete, misleading, or untruthful may result in termination, criminal sanctions, or delays in processing this form for employment.

Employee Signature:	Date

PART 8 - VITAL SIGNS, VISION, HEARING*

Uncorrected Vision

Far: OU (both) 20/ _____
OD (right) 20/ _____
OS (left) 20/ _____

Near: OU (both) 20/ _____
OD (right) 20/ _____
OS (left) 20/ _____

Corrected Vision

Far: OU (both) 20/ _____
OD (right) 20/ _____
OS (left) 20/ _____

Near: OU (both) 20/ _____
OD (right) 20/ _____
OS (left) 20/ _____

Visual Fields

Horizontal	Vertical
OD _____ degrees	OD _____ degrees
OS _____ degrees	OS _____ degrees

Depth Perception: _____ Seconds of Arc

Color Vision

Ishihara: # correct _____ out of # tested _____

**Full uncorrected and corrected vision, visual fields, depth vision and color vision are required for laborers, crane operators, forklift operators, firefighters, and CGIS workers. The normal monocular peripheral visual field is 100 degrees laterally and 60 degrees medially (total 160 degrees) and 60 degrees upward and 75 degrees downward (total 135 degrees).*

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PART 9 - PHYSICAL EXAMINATION

	NORMAL	ABNORMAL	NOT DONE	COMMENTS
GENERAL	☐	☐	☐	
SKIN	☐	☐	☐	
HEAD	☐	☐	☐	
EYES	☐	☐	☐	
EARS	☐	☐	☐	
NOSE	☐	☐	☐	
MOUTH	☐	☐	☐	
THROAT	☐	☐	☐	
NECK	☐	☐	☐	
THYROID	☐	☐	☐	
LYMPH NODES	☐	☐	☐	
LUNGS	☐	☐	☐	
HEART	☐	☐	☐	
ABDOMEN	☐	☐	☐	
GENITALIA	☐	☐	☐	
INGUINAL HERNIA	☐	☐	☐	
EXTREMITIES	☐	☐	☐	
ARTERIAL PULSES	☐	☐	☐	
MUSCULOSKELETAL	☐	☐	☐	
NEUROLOGICAL	☐	☐	☐	
MENTAL STATUS	☐	☐	☐	
RECTAL*	☐	☐	☐	
BREAST**	☐	☐	☐	

* Prostate exam over age 40 *(Cadmium, Ionizing radiation)*; Fecal occult blood test *(Firefighters ≥ 40)*;
** Female breast exam over age 40 *(Ionizing radiation)*.

PART 11 - MEDICAL DIAGNOSIS/ABNORMAL FINDINGS

Medical Diagnosis/Abnormal Finding	ICD-Code	Recommended Evaluation/Treatment

Recommended work restrictions

Name of Examiner (print)	Examiner's Signature:	Date

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