FEDERAL OCCUPATIONAL HEALTH

MEDICAL SURVEILLANCE MANAGEMENT PROGRAM

HEALTH HISTORY AND PHYSICAL EXAMINATION FORM

Part I. Personal Information and Medical History

(to be completed by the employee before the examination

For FOH Office Use Only
Agree. #:_____
OHC/Z-code:_____
Source of Exposure History:
☐ **Agency Set or Standard**
☐ **IH Interview**
☐ **Part II, Sec. 2 MSMP Form**

A comprehensive history is an important part of your medical record. Please complete Part I and II of this questionnaire by placing a check mark (√) in the appropriate spaces or **printing** other information where requested (use black or blue ink). Return form to the site where your exam will be done. Please see the **Privacy Act Notice** on the next page.

IDENTIFICATION Today's Date _____

Sex: [ ] Male [ ] Female

Check One: [ ] Black (non-Hispanic) [ ] White (non-Hispanic) [ ] American Indian/Alaskan Native [ ] Hispanic [ ] Asian [ ] Pacific Islander

LAST NAME FIRST (No nicknames) MIDDLE

_____-_____-_____ / / _____

SOCIAL SECURITY NO. BIRTHDATE PLACE OF BIRTH: Country State City

YOUR EMPLOYER: AGENCY DIVISION ORGANIZATIONAL UNIT NAME OF SUPERVISOR SUPERVISOR'S TELEPHONE NO.

YOUR OFFICIAL OPM JOB TITLE AND JOB SERIES NUMBER YOUR WORK BUILDING/FACILITY YOUR WORK TELEPHONE NO.

YOUR HOME MAILING ADDRESS CITY, STATE ZIP HOME TELEPHONE NO.

MEDICATIONS

List ALL medications (including prescription, non-prescription, vitamins and herbal preparations) you currently take:

_____ _____

_____ _____

SOCIAL HISTORY

Have you ever used tobacco? [ ]Yes [ ]No

If "yes", When: [ ] Current [ ] Past - years since quitting? _____

Type: [ ] Cigarettes [ ] Pipe/Cigar [ ] Snuff/Chewing
Amount per day? _____ For how many years? _____

What is your average alcohol consumption in a week? _____ drinks
(1 drink = 12 oz. beer, 1 glass wine or 1.5 oz liquor)

If you drink alcohol, what is your usual pattern?
[ ] Weekdays [ ] Weekends [ ] Both

MEDICAL HISTORY

Which of the following conditions have you ever had?
Enter year of diagnosis, if known, or place √ if unknown.

[ ] Allergies Specify:_____
[ ] Anemia
[ ] Asthma
[ ] Broken bones
[ ] Cancer history
[ ] Claustrophobia
[ ] Collapsed lung
[ ] Diabetes
[ ] Denture use
[ ] Emphysema
[ ] Heart attack
[ ] Heart murmur
[ ] Hepatitis
[ ] Herniated disc
[ ] High blood pressure
[ ] Head Injury
[ ] Kidney disease
[ ] Loss of consciousness
[ ] Migraines
[ ] Positive skin test for TB
[ ] Prostate problems
[ ] Ruptured ear drum
[ ] Seizures
[ ] Thyroid trouble

Other medical disorders - Specify:

_____ _____

_____ _____

Year of last tetanus booster: _____

Year of last chest x-ray: _____

Have you received Hepatitis B vaccine? [ ] Yes [ ] No

If "yes", number of shots: [ ] 1 [ ] 2 [ ] 3 Year completed: _____

HOSPITALIZATIONS AND SURGERIES

YEAR REASON (continue on the back, if more space is needed)

_____ _____

_____ _____

_____ _____

LEISURE ACTIVITIES

In which of the following hobbies/activities do you participate?

[ ] Painting [ ] Ceramics/Pottery [ ] Guns/hunting
[ ] Gardening [ ] Refinishing [ ] Stained glass
[ ] Auto/boat repair [ ] Power tool usage [ ] Other (specify below):

_____

Do you use safety equipment when you engage in these activities? [ ]Yes [ ] No

OTHER QUESTIONNAIRES **[FOH Office Use Only]**

Please indicate those additional questionnaires that are necessary, based on the examinee's exposure history and agency requirements. If additional questionnaires are completed, attach them to this Health History form, and indicate "Completed" in the space, below.

	Needed	Completed
Audiogram History / Report (FOH-17)	[ ]	[ ]
Tuberculosis Screening Form (FOH-25)	[ ]	[ ]
Cadmium Exposure History (FOH-[pending])	[ ]	[ ]
Reproductive Health Effects History (FOH-[pending])	[ ]	[ ]
Initial Asbestos Medical Questionnaire (FOH-7)	[ ]	[ ]
Periodic Asbestos Medical Questionnaire (FOH-8)	[ ]	[ ]

Privacy Act Statement

The collection and use of this information is authorized by 5 U.S.C. 7901 (Health Service Programs) and 29 U.S.C. 657 (Occupational Health and Safety; Record Keeping). The information will become part of your official Employee Medical File, and will be used to assist Federal Occupational Health in carrying out its occupational health services responsibilities under one or more interagency agreements with your employing agency, and for other official purposes and routine uses as described in Privacy Act systems notice OPM/GOVT-10 (Employee Medical File System Records). Providing the requested information is voluntary. Not providing the information may affect the availability and quality of health services rendered to you, and may also affect the completeness of information used by your agency in making determinations of medically-related employment decisions.

REVIEW OF SYSTEMS - Which of the following have been a problem for you ***in the last year***?

General/Constitutional

[ ] Fever, >100°
[ ] Shivering/ chills
[ ] Generalized weakness
[ ] Unexplained weight loss/gain
[ ] Excessive fatigue
[ ] Swollen glands
[ ] Loss of appetite

Eyes

[ ] Change in vision
[ ] Itching
[ ] Tearing

Ears, Nose, Throat

[ ] Difficulty hearing
[ ] Ringing, buzzing
[ ] Sinus trouble
[ ] Sneezing/runny nose
[ ] Nosebleeds
[ ] Difficulty swallowing

Heart/Lungs

[ ] Chest pain or pressure
[ ] Irregular heart beat
[ ] Palpitations/skipped beats
[ ] New or changed cough
[ ] Coughing up blood
[ ] Wheezing
[ ] Shortness of breath

Digestive System

[ ] Nausea/vomiting
[ ] Diarrhea/Constipation (*circle one or both*)
[ ] Yellow jaundice
[ ] Rectal bleeding or black tarry stools

Neurologic/Psychiatric

[ ] Headaches
[ ] Dizziness/passing out (*circle one or both*)
[ ] Depression
[ ] Numbness or tingling
[ ] Excessive anxiety
[ ] Insomnia / difficulty sleeping
[ ] Loss of memory

Skin/musculoskeletal

[ ] Rashes
[ ] Moles that changed in size or color
[ ] Muscle pain
[ ] Back pain
[ ] Neck pain
[ ] Weakness in arms/legs
[ ] Joint pain

Genitourinary & Reproductive

[ ] Difficult or painful urination
[ ] Blood in urine
[ ] Difficulty having children

(Men Only)

[ ] Lump in Testicle
[ ] Impotence

(Women Only)

[ ] Irregular periods/spotting
[ ] Miscarriage or stillborn pregnancy
[ ] Breast lump/discharge
[ ] Currently or possibly pregnant

Examiner's comments: [All positive responses in the medical history (section 4), hospitalization and surgery (section 5), and review of systems (section 9), above, should be commented upon here.]

Part II. Occupational and Exposure History (*to be completed by the employee before the examination*)

Section 1, OCCUPATIONAL HISTORY **(*Section 2., EXPOSURE HISTORY,* is a separate form that also may be required)**

Briefly describe the activities of your current job:_____

_____

_____

How long have you been doing this type of work? _____ years

Have you ever been off work more than a day because of ***work-related*** illness or injury? [ ] Yes [ ] No

If "yes", specify _____

Have you ever changed jobs or duties due to health problems? [ ]Yes [ ] No

If "yes", specify _____

If this is your *first* FOH medical surveillance exam, list all *previous* jobs , starting with the one *before* your current position:

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

* **Hazards include asbestos, chemicals, dusts, fumes, gases, radiation, vibration, repetitive motion, intense light and loud noise.**

*** For *any* asbestos exposure, please indicate the year and place of first exposure, regardless of use of protective equipment:**

Employee Name:_____

Part III. Physical Examination
(*to be completed by the examiner at the time of the examination*)

Physical Examination, Section 1 (Record the results of all services that are provided.)

Vital Signs: _____(in.) _____(lb.) _____/_____(mm/Hg) _____ _____ _____

Height Weight Blood Pressure Pulse Temperature Respirations

Health Center Stamp

Tonometry: O.D: _____mm/Hg
O.S: _____
[ ] not done

Mantoux (PPD) [ ] _____ mm. induration
[ ] not done

Stool for Occult Blood [ ] neg x 3
[ ] positive
[ ] not done

Best Vision: Testing method ☐ screening machine ☐ wall/hand held chart

[ ]Uncorrected	[ ] With Correction Correction Type: ☐ Contacts ☐ Glasses	Comments:
Near: OU (both) 20/_____ OD (right) 20/_____ OS (left) 20/_____	Near: OU (both) 20/_____ OD (right) 20/_____ OS (left) 20/_____	
Far: OU (both) 20/_____ OD (right) 20/_____ OS (left) 20/_____	Far: OU (both) 20/_____ OD (right) 20/_____ OS (left) 20/_____	

Peripheral vision (degrees)	Color Vision (test used:)	Depth Perception (test type and seconds of arc)
right Temporal ° _____ left Temporal ° _____ Nasal ° _____ Nasal ° _____ Total ° _____ Total ° _____	Number correct: _____ of _____ tested Can see red/green/yellow? Yes No	

Spirometry:

Actual FVC	Actual FEV1	Actual FEV1/FVC	Actual FEF 25-75
%Predicted FVC	%Predicted FEV1	%Predicted FEV1/FVC	%Predicted FEF 25-75
Comments:			

Audiometry:

With hearing aid? No___ Yes___ (Type:)

Frequency	500Hz	1000Hz	2000Hz	3000Hz	4000Hz	6000Hz	8000Hz
Right ear							
Left ear							

TMs visible (right and left) ? [ ]Yes [ ] No

Standard Threshold Shift present? [ ]Yes [ ] No

Comments:

Employee Name:_____

Physical Examination, Section 2

	Normal	Abnormal	Not Done	Comment:
General	[ ]	[ ]	[ ]	
Skin	[ ]	[ ]	[ ]	
Head	[ ]	[ ]	[ ]	
Eyes	[ ]	[ ]	[ ]	
Ears	[ ]	[ ]	[ ]	
Nose	[ ]	[ ]	[ ]	
Mouth	[ ]	[ ]	[ ]	
Throat	[ ]	[ ]	[ ]	
Neck	[ ]	[ ]	[ ]	
Thyroid	[ ]	[ ]	[ ]	
Lymph Nodes	[ ]	[ ]	[ ]	
Lungs	[ ]	[ ]	[ ]	
Breasts	[ ]	[ ]	[ ]	
Heart	[ ]	[ ]	[ ]	
Abdomen	[ ]	[ ]	[ ]	
Genitalia	[ ]	[ ]	[ ]	
Rectal	[ ]	[ ]	[ ]	
Extremities	[ ]	[ ]	[ ]	
Arterial Pulses	[ ]	[ ]	[ ]	
Musculoskeletal	[ ]	[ ]	[ ]	
Neurologic	[ ]	[ ]	[ ]	
Mental Status	[ ]	[ ]	[ ]	

INTERPRETATION OF LAB AND OTHER SCREENING RESULTS

	Normal	-----Abnormal----- Clinically Insignificant	Clinically Significant	Not Done		Normal	-----Abnormal----- Clinically Insignificant	Clinically Significant	Not Done
Chem Profile									
Liver function	[ ]	[ ]	[ ]	[ ]	Audiometry	[ ]	[ ]	[ ]	[ ]
Renal function	[ ]	[ ]	[ ]	[ ]	Chest x-ray	[ ]	[ ]	[ ]	[ ]
Other chemistries	[ ]	[ ]	[ ]	[ ]	B-reading	[ ]	[ ]	[ ]	[ ]
CBC	[ ]	[ ]	[ ]	[ ]	EKG	[ ]	[ ]	[ ]	[ ]
Urinalysis	[ ]	[ ]	[ ]	[ ]	ETT (Stress Test)	[ ]	[ ]	[ ]	[ ]
ZPP	[ ]	[ ]	[ ]	[ ]	Spirometry	[ ]	[ ]	[ ]	[ ]
Lead (blood)	[ ]	[ ]	[ ]	[ ]	Tonometry	[ ]	[ ]	[ ]	[ ]
Heavy Metal Screen	[ ]	[ ]	[ ]	[ ]	Visual Acuity	[ ]	[ ]	[ ]	[ ]
Plasma Cholinesterase	[ ]	[ ]	[ ]	[ ]	Stool for Occult Blood	[ ]	[ ]	[ ]	[ ]
RBC Cholinesterase	[ ]	[ ]	[ ]	[ ]	PPD (Mantoux)	[ ]	[ ]	[ ]	[ ]
PCBs	[ ]	[ ]	[ ]	[ ]	Other_____	[ ]	[ ]	[ ]	[ ]

Comments:

Employee Name:_____

FEDERAL OCCUPATIONAL HEALTH

MEDICAL SURVEILLANCE MANAGEMENT PROGRAM

MEDICAL HISTORY AND PHYSICAL EXAMINATION FORM

Part IV. Examiner's Summary

(*to be completed by the examiner at the time of the examination*)

ASSESSMENT / REFERRAL PLAN

	Comments:	Not Referred	--Referred--- Routine	Urgent
1._____	_____	[ ]	[ ]	[ ]
2._____	_____	[ ]	[ ]	[ ]
3._____	_____	[ ]	[ ]	[ ]
4._____	_____	[ ]	[ ]	[ ]
5._____	_____	[ ]	[ ]	[ ]

RECOMMENDATIONS / EDUCATION SUMMARY **[Note: this is NOT a clearance summary; see Part V, Report to Employer]**

THE FOLLOWING TOPICS AND RECOMMENDATIONS MARKED WITH A "√" WERE DISCUSSED WITH THE EMPLOYEE:

[ ] Protective Equipment

- [ ] Hearing Protection
- [ ] Safety glasses
- [ ] Respirator use
- [ ] Gloves/Skin protection
- [ ] Seat belts
- [ ] Other _____

- [ ] Smoking cessation
- [ ] Dangers of smoking and asbestos exposure
- [ ] Reduce or stop alcohol consumption
- [ ] Participate in regular cancer screening
- [ ] Self examination (breast, testicular)
- [ ] Universal Precautions for BBP
- [ ] Avoid sun exposure/Use sun block
- [ ] Other _____

_____ Name of Examiner (print)

_____ Examiner's signature

_____ Date

I have received a copy of the summary of my examination and understand the recommendations:

_____ Employee Signature

_____ Date

FEDERAL OCCUPATIONAL HEALTH

MEDICAL SURVEILLANCE MANAGEMENT PROGRAM

MEDICAL HISTORY AND PHYSICAL EXAMINATION FORM

Part V. Report to Employee
(*to be completed by the reviewer*)

NAME _____ **SSN** _____

AGENCY _____ **EXAM DATE** _____

Summary of occupational medicine consultant review: Confidential report to the employee

The examiner who performed your medical surveillance exam should have discussed important findings of the exam, and made suggestions to you about any medical follow-up that was needed. Your medical surveillance exam records also have been reviewed by an occupational medicine consultant, and compared to results from prior medical surveillance exams when these were available. This form provides the impressions of the medical consultant after reviewing your records, along with the consultant's recommendations for work modifications and suggestions for follow-up. This confidential information IS NOT shared with your supervisor.

1. **Possible health effects from recent workplace exposures:**
   __None noted
   _____
   _____
   _____

2. **Health problems not caused by work, and which do not affect your ability to perform job duties safely and efficiently:**
   __None noted
   _____
   _____
   _____
   _____

3. **Health problems not caused by work, but which <u>may</u> affect your ability to perform job duties safely and efficiently:**
   __None noted
   _____
   _____
   _____
   _____

4. **Follow-up needed as part of the medical surveillance exam program (please send to the address given below)**
   __None required
   _____
   _____
   _____

5. **Other comments by the occupational medicine consultant**
   _____
   _____
   _____

If you have questions, please call me at _____,

_____ _____ _____
Reviewer's Name (Print) **Reviewer's Signature** **Date**

_____
Address

FEDERAL OCCUPATIONAL HEALTH

MEDICAL SURVEILLANCE MANAGEMENT PROGRAM

MEDICAL HISTORY AND PHYSICAL EXAMINATION FORM

Part VI. Report to Employer

(*to be completed by the reviewer*)

NAME _____ **SSN** _____

AGENCY _____ **EXAM DATE** _____

Medical Opinion: (*check all that apply*)

The employee has been informed of the following medical opinion.

[ ] No medical findings were noted that indicate work-related injury/illness.
Where nonwork-related significant findings were noted, a referral has been made at the employee's expense.

[ ] Medical findings support a work-related injury/illness or hazardous exposure, see recommendations below.

[ ] Medical findings or exposure history warrant a review of work activities, see recommendations below.

[ ] Decision deferred, additional documentation needed. Please provide the documentation listed below..

[ ] Work limitations recommended. (*Specify limitations and re-evaluation date below*).

Comments/Recommendations/Limitations:

_____

_____

_____

Limitations should be reevaluated _____ (*Date*)

Clearances:

[ ] Employee has been cleared for the routine duties outlined in the provided job description.

[ ] Motor Vehicle Clearance (DOT/DMV) Expires _____

[ ] Other. Specify _____ Expires _____

(e.g.,, crane operator, diver, fire fighter, arduous duty)

Respirator Clearance (select one box ☐ and provide comments as appropriate)

☐ ***This employee has been found to be physically able to use the following (check each [ ] that applies):***
(see Respirator Medical Evaluation Questionnaire form for specific types and uses requiring clearance)

[ ] Single use, filter mask (four attachment points)
[ ] Full-faced cartridge-type respirator, negative pressure
[ ] Full-faced powered cartridge-type (PAPR)
[ ] Hood/helmet powered cartridge-type (PAPR) (NOT positive pressure)
[ ] Half-faced cartridge-type, negative pressure
[ ] Half-faced powered cartridge-type (PAPR)
[ ] Self-contained breathing apparatus (SCBA)
[ ] Half-faced/Full-faced/Hood/Helmet (positive pressure airline respirator)

When wearing a respirator, the employee has been informed to limit activity level* to the following (check one [ ]):

[ ] Mild Exertion [ ] Moderate Exertion [ ] Heavy Exertion (No specified limitations)

Other limitations needed (if any) when wearing a respirator:

_____

_____

This respirator clearance expires 1 2 3 years from the date below. (*If not marked, clearance expires in 1 year*)
(*circle one*)

☐ ***This employee has been found to be physically NOT able to use a respirator***

☐ ***There is insufficient information to make a determination at this time***

The following additional tests, or medical information, will be required in order to make a determination regarding the safe use of a respirator by this employee:

_____

_____

Reviewer's Name (Print) **Reviewer's Signature** **Date**

* Light/Mild exertion (2-3 METS)= negligible lifting, extended walking (flat surface), extended standing, writing
Moderate exertion (4-5 METS) = lifting 10lbs (5 or more lifts/min), fast walking (4mph), gardening/digging, pushing, pulling
Heavy exertion (5-10 METS) = jogging (10 minute mile), chopping wood, climbing hills, life-saving activities, firefighting