MEDICAL EXAMINATION AND HISTORY REPORT

SELECTEES: Please DO NOT write in "EXAMINING FACILITY USE ONLY" areas.

SELECTEES: Complete page 1 through 5 before reporting for the medical examination. **Failure to answer any questions or disclose a known medical condition or history of a medical condition or injury or failure to place signature where indicated may result in disqualification from employment consideration.** Please print or type. Each "yes" answer to a medical history question requires that you provide a brief explanation in the comment section provided. This examination is being conducted for employment purposes only; it does not substitute for a periodic health examination conducted by your private provider. (NOTE: Because this exam may include a fitness test, please dress appropriately.)

ATTENTION VETERANS: All mental health counseling or treatment, to include counseling that was "strictly related to adjustments from service in a military combat environment", **must** be disclosed on this Medical Examination and History Report form to determine if you meet the medical qualifications for the position.

SELECTEE'S NAME (Last, First, Middle Initial):		SOCIAL SECURITY NUMBER (SSN)/IDENTIFICATION (ID) NUMBER:
VETERAN'S PREFERENCE ELIGIBILITY: ☐ Yes ☐ No If yes, specify below: □ 5-point preference □ 10-point preference	SEX: ☐ Male ☐ Female	DATE OF BIRTH: (mm/dd/yy)
YOUR CURRENT OCCUPATION:	YOUR CURRENT EMPLOYER:	
HOW LONG IN CURRENT POSITION? (years/months)		

PURPOSE OF EXAMINATION:
☐ Pre-Employment Exam

CHECK THE OCCUPATION FOR WHICH YOU ARE BEING CONSIDERED:
☐ Criminal Investigator (GS-1811)
☐ Deportation Officer (GS-1801)
☐ Police Officer (GS-0083)
☐ Law Enforcement Training Specialist (GS-1701)
☐ Physical Security Specialist (GS-0800)
☐ Other: _____

EXAMINING FACILITY USE ONLY

EXAMINING FACILITIES: **(Do NOT bill examinee for exam. (VENDOR NAME) is responsible for all payments.)** Conduct medical exam and all other required services in accordance with instructions provided by the contracting organization. Complete this form except where indicated. Please print or type.

NAME AND ADDRESS OF EXAMINIG FACILITY:	NAME OF EXAMINING PHYSICIAN/NP/PA:
	PHONE NUMBER: (including area code)

REQUIRED SERVICES: (check when completed and attach reports)

- ☐ Medical History and Examiner Review
- ☐ General Physical Examination (including waist measurements and fitness questionnaire)
- ☐ Tuberculosis (TB) Test
- ☐ Fitness Step Test (if applicable)
- ☐ Examiner Review and Comments
- ☐ EKG (with signed interpretation)
- ☐ Audiometry
- ☐ Repeat Audiometry, if appropriate
- ☐ Vision Screening

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

MEDICAL HISTORY

Selectee to Complete This Section

Check "yes" or "no" for **each** item. For each "yes", you must provide an explanation in the space below. **Explanations to "yes" answers must include date, body part affected, description of injury/issue, and type of treatment.**

1. Have you ever been refused employment or been unable to hold a job or stay in school due to any medical condition? (If yes, specify date, where and give details.) ☐ Yes ☐ No

2. Have you had any surgery or operation? (If yes, describe and give date, details or problem, and name of procedure) ☐ Yes ☐ No

3. Have you been advised to have any surgery or operation, but chose not to have that treatment? (If yes, describe and give date, details or problem, and name of procedure.) ☐ Yes ☐ No

4. Have you ever been a patient in any type of hospital or emergency room? (If yes, specify date, where, why) ☐ Yes ☐ No

5. Have you consulted or been treated by clinics, physicians, healers, or other practitioners for other than minor illness for which no medications were prescribed? (If yes, give date and complete details) ☐ Yes ☐ No

6. Have you ever been rejected for or separated from military service because of physical, mental or other medical reasons? (If yes, give date and reason) ☐ Yes ☐ No

7. Have you ever applied for or received VA (Veteran's Administration) disability? (If yes, please attach a copy of all rating decisions, or application if pending decision) ☐ Yes ☐ No

Percentage Granted:_____% Year Granted: _____

Issue and Related Percentage (for example, PTSD 50%, etc.):

8. Have you ever applied for or received pension or compensation for a non-VA disability? (If yes, please attach a copy of all rating decisions, or application if pending decision) ☐ Yes ☐ No

Type of Disability (SSDI, Worker's Comp, etc.): _____

Permanent or Temporary:_____ Percentage Granted:_____% Year Granted: _____

Issue and Related Percentage:

9. Are you: ☐ Left Handed OR ☐ Right Handed

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

10. Do you take any medications or use inhalers? ☐ Yes ☐ No

If yes, list prescription and non-prescription medications, dosage, and reason for taking (including inhalers).

Medication	Dosage/Frequency	Reason	Currently Taking	Taken in the Past Year
1.			☐	☐
2.			☐	☐
3.			☐	☐
4.			☐	☐

*Attach additional sheets if necessary.

11. Do you have allergies? ☐ Yes ☐ No

If yes, do you carry an Epi pen? ☐ Yes ☐ No

If you have allergies, list substances to which you are allergic, the type of reaction, and any medications taken for treatment. If any allergies are to foods, explain if you can be exposed to them (skin contact) without having a reaction.

What are you allergic to?	Specify the allergy and type of reaction (rash, breathing problem, etc.)	Medications Used
☐ Environmental		
☐ Food (including peppers)		
☐ Insects (bees or other stinging insects)		
☐ Animals		
☐ Medication		

*Attach additional sheets if necessary.

MEDICAL HISTORY

(Selectee to complete this section)

Do you currently have, or have any history of the following? Describe all "YES" answers on page 6.

	YES	NO
EYES		
12. Detached retina or surgery to repair		
13. Cataracts or surgery for cataracts		
14. Glaucoma		
15. Keratoconus		
16. Strabismus or "lazy eye" or any surgery to correct these		
17. Any other eye disease, injury, or surgery		
VISION		
18. Wear contacts *If yes, how long:		
19. Wear glasses *If yes, bring your eyeglasses with you to your appointment		
20. Surgery to improve vision (RK, PRK, LASIK, etc.) *If yes, year:		
21. Loss of vision in either eye		
22. Color vision deficiency or color blindness		
23. Night vision deficiency or night blindness		
24. Blurred or double vision		
EARS		
25. Perforated ear drum or tubes in ear drum(s)		
26. Chronic ear pain/infection		
27. Ear surgery		
28. Loss of balance or vertigo		
29. Ringing or buzzing		
HEARING		
30. Difficulty hearing		
31. Hearing loss		

	YES	NO
HEARING (cont'd)		
32. Prescribed and/or wear a hearing aid *If yes, specify: □ Right □ Left □ Both		
33. Loud, constant noise within past 15 hours		
34. Loud, sudden noise within past 15 hours		
NOSE, SINUSES, MOUTH, LARYNX		
35. Ear, nose, or throat trouble or disease		
36. Chronic sinus infections		
37. Recurrent nose bleeds *If yes, last episode_____		
38. Absence of, or disturbance of sense of smell		
39. Any surgery of your face, mandible, or jaw		
LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM		
40. Shortness of Breath		
41. Wheezing		
42. Chronic Bronchitis		
43. Chronic cough or frequent coughing at night		
44. Collapsed lung or other lung disease		
45. History of chest/chest wall/or breast surgery		
46. Asthma (after age 13) *If yes, date of last ER visit(s) or hospitalization(s):		
47. Inhaler use *If yes, how often: Last Used:		

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

	YES	NO
LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM (cont'd)		
48. Other breathing problems worsened by exercise, weather, pollen, etc.		
HEART		
49. Heart murmur or valve problem		
50. Palpitation, pounding heart or abnormal heartbeat		
51. Heart surgery		
52. Pain or pressure in the chest		
53. Abnormal electrocardiogram (EKG)		
54. Heart problems or heart disease		
ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM		
55. Stomach, esophageal or intestinal ulcer		
56. Difficulty swallowing		
57. Frequent indigestion or heartburn		
58. Gall bladder trouble or gallstones		
59. Liver disease or Hepatitis		
60. Hernia		
61. Surgery to remove or repair a portion of the intestine (other than appendix)		
62. Chronic or recurrent intestinal problem such as Irritable Bowel Syndrome, Crohn's disease, Ulcerative Colitis, or Celiac Disease		
63. Rectal disease, hemorrhoids, or blood from rectum		
64. Hemorrhoid surgery		
65. Bariatric surgery (weight loss surgery)		
FEMALES		
66. Currently pregnant		
67. Chronic pelvic pain		
68. Diagnosed with endometriosis or ovarian cysts		
69. Evaluation, treatment, or surgery for any other gynecological (female) disorder		
70. Permanent complications of any sexually transmitted disease		
71. Malignant disease of the bladder, kidney, ureter, cervix, ovaries, breasts, etc.		
MALES		
72. Varicocele, hydrocele, or any scrotal mass, swelling or pain		
73. Prostate problems		
74. Permanent complications of any sexually transmitted disease		
75. Malignant disease of the bladder, kidney, ureter, prostate, testicles, etc		
URINARY SYSTEM		
76. Missing a kidney		
77. Renal transplant		
78. Kidney stone, infection, or disease		
79. Kidney or urinary tract surgery		
80. Painful or difficult urination		
81. Blood or protein in urine		
SPINE AND SACROILIAC JOINTS		
82. Recurrent back pain or back problem		
83. Herniated disk		
84. Recurrent neck pain		
85. Back or neck surgery		
86. Abnormal curvature of spine (any part)		

	YES	NO
UPPER EXTREMITIES		
87. Painful shoulder, elbow, wrist, hand, or fingers		
88. Dislocated shoulder, elbow, wrist, hand, or fingers		
LOWER EXTREMITIES		
89. Foot trouble (i.e. painful bunions, warts, ingrown toenails, etc.		
90. Knee trouble (i.e. locking, giving out, or ligament injury, etc.		
91. Painful hip, knee, ankle, foot or toes		
92. Dislocated hip, knee, foot, or toes		
MISCELLANEOUS CONDITIONS OF THE EXTREMITIES		
93. Bone, joint, or other orthopedic deformity		
94. Loss of finger or toe, or extra finger or toe		
95. Loss of the ability to fully flex (bend) or fully extend a finger, toe, or other joint		
96. Impaired use of arms, hands, legs, or feet (any reason)		
97. Arthritis, rheumatism, or bursitis		
98. Any swollen joint(s) or gout		
99. Surgery on any joint/bone (including arthroscopy)		
100. Plate(s), screw(s), rod(s) or pin(s) in any bone		
101. Pain or swelling at the site of an old fracture		
102. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics		
103. Any other orthopedic, muscle, or sports injury problems		
104. Physical therapy within the last two years		
VASCULAR		
105. High or low blood pressure		
106. Raynaud's phenomenon or disease		
107. Deep Vein Thrombosis (blood clot; leg or elsewhere)		
108. Pulmonary embolism (blood clot in lung)		
SKIN AND CELLULAR		
109. Acne or psoriasis requiring prescription medication within the last two years		
110. Eczema		
111. Atopic dermatitis (after age 12)		
112. Large or painful scars		
113. Any other skin problems		
BLOOD AND BLOOD FORMING TISSUES		
114. Anemia		
115. Any other blood or circulation problems		
SYSTEMIC		
116. Tuberculosis		
117. Positive test for tuberculosis (PPD or blood test) *If yes, when_____		
118. Taken immunosuppressive drugs within the past year (steroids, chemotherapy, etc.)		
119. Disorder(s) of immune system (including HIV)		
120. Car, train, sea, or air sickness		
ENDOCRINE AND METABOLIC		
121. Thyroid trouble or goiter		
122. High or low blood sugar		
123. Diabetes		

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

	YES	NO
NEUROLOGIC		
124. Cerebrovascular accident (stroke)		
125. Skull fracture		
126. Frequent or severe headaches to include migraines		
127. Lost time from work or school due to frequent or severe headaches		
128. A head injury, memory loss, or amnesia or Traumatic Brain Injury (TBI)		
129. A period of unconsciousness or concussion		
130. Seizures, convulsions, epilepsy or fits		
131. Meningitis, encephalitis, or other neurological problems		
132. Paralysis		
133. Dizziness or fainting spells		
134. Any other neurologic problems		
SLEEP DISORDERS		
135. Sleepwalking or narcolepsy		
136. Frequent trouble sleeping/Insomnia		
137. Sleep Apnea		
138. Use of CPAP *If yes, please submit CPAP compliance data from within the past 90 days showing compliance rates for a minimum of 30 days		
LEARNING, PSYCHIATRIC, BEHAVIORAL		
139. Evaluated or treated for Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)		
140. Taken (or taking) medication (s), drugs, or any substance to improve attention, behavior, or physical performance		
141. Diagnosed with a learning disorder, to include dyslexia		
142. Seen a psychiatrist, psychologist, social worker, counselor or other professional for any reason (inpatient or outpatient) including counseling or treatment for school, adjustment, family, marriage, divorce, depression, anxiety, or treatment of alcohol, drug or substance abuse		
143. Been evaluated or treated, either with medication or counseling, for a mental condition (i.e. depression, or excessive worry, etc.		
144. Been expelled or suspended from school		
145. Anorexia, bulimia, or other eating disorder		
146. Habitual stammering or stuttering		
147. Have you ever purposely cut or harmed yourself		
148. Have you ever attempted or considered suicide *If yes, when:		

	YES	NO
LEARNING, PSYCHIATRIC, BEHAVIORAL (cont'd)		
150. Have you been evaluated, treated, or hospitalized for substance abuse, addiction or dependence (including illegal drugs, prescription medications or other substances)		
151. Have you been evaluated, treated, or hospitalized for alcohol abuse, dependence, or addiction		
152. Have you ever been diagnosed with Post-Traumatic Stress Disorder (PTSD)		
153. Any other learning, psychiatric, or behavioral problems		
TUMORS AND MALIGNANCIES		
154. Tumor, growth, cyst, or cancer of any type		
MISCELLANEOUS		
155. Cold injury, frostbite or cold intolerance		
156. Heat injury, heat stroke or heat intolerance		
157. Have you ever had, or are you currently being treated for any other illness or injury not already mentioned *If yes, describe details and dates on page 6		
158. Have you ever smoked *If yes, complete the following: _____ Current _____ Past Type: ☐ Cigarettes ☐ Cigars ☐ Pipe How many per day: _____ How long: _____		
159. Alcohol Use *If yes, complete the following: Number of drinks per week/month _____ (Scale: 1 drink- 12 oz. beer, 1 glass of wine, 1.5 oz. liquor) When do you drink alcohol? ☐ Weekday ☐ Weekend ☐ Both		

***** END OF MEDICAL HISTORY QUESTIONNAIRE. *****

REMEMBER TO PROVIDE A DETAILED EXPLANATION OF ALL "YES" RESPONSES ON PAGE 6.

Please bring the following with you to your appointment:

1. **For ANY medical condition(s) for which you have been evaluated within the last two years, please bring clinical treatment records.**
2. **For ANY surgical procedures or orthopedic injuries within the past three years, please bring treatment records, operative reports, and any physical therapy discharge summaries**
3. **For ANY mental health conditions treated within the past five years, or for which there is a current disability rating, please bring mental health treatment records for the past two years or treatment records after the award of the disability rating**

149. Used illegal drugs or abused prescription drugs			

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

SELECTEE AND EXAMINER COMMENTS

(Selectee and Examiner to Complete This Section)

For all "yes" answers from prior pages, explain in detail. If additional sheet is needed, use page 6a at end of form.

SELECTEE			EXAMINER
Question Number	Date of Injury/Date of Diagnosis (month/year)	Explain in detail the diagnosis, how injury/illness occurred, symptoms, body part affected, type of treatment, current symptoms, etc.	Examiner's Comments

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

FITNESS QUESTIONNAIRE

(Selectee to Complete This Section)

BEFORE answering the following, please read the Practical Exercise Performance Requirements (PEPR) you received from the Dallas Service Center which was included in the Employment Information Booklet. If there are ANY physical tasks or training exercises on the PEPR that you currently CANNOT perform, list them below.

1. Are you familiar with the physical requirement of the position for which you applied? ☐ Yes ☐ No

2. Are you capable of performing the following?
   - Vigorous aerobic activity at least 3 hours/week ☐ Yes ☐ No
   - 1 ½ mile time run ☐ Yes ☐ No
   - ¼ mile run ☐ Yes ☐ No
   - Quickly get in/out of mid-sized car with ease ☐ Yes ☐ No
   - Squat or kneel for up to 45 seconds repeatedly ☐ Yes ☐ No
   - Kneel for 2-3 minutes at a time repeatedly ☐ Yes ☐ No

3. Do you have any lifting restrictions? ☐ Yes ☐ No
   - If yes, what is the maximum number of pounds you are allowed to lift _____ lbs.

Selectee's Comments: If you indicated that you are **INCAPABLE** of performing one of the activities in question 2 above, please provide an explanation below: □ N/A

Examining Physician Comments: □ N/A

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. Furthermore, consistent with the Privacy Act Statement, I authorize the release to my employing agency of all information contained on this examination from and all other forms generated as a direct result of my examination.

SELECTEE MUST SIGN BELOW IN THE PRESENCE OF A WITNESS FROM THE EXAMINING FACILITY.

SELECTEE'S SIGNATURE DATE:

WITNESS SIGNATURE DATE:

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

VISION TESTING
(Examiner to complete This Section)

DEPTH PERCEPTION

Check Test Used:
☐ **Titmus Stereo** ☐ **Titmus Vision Screener** ☐ **Other**

_____of_____total number

Document the number of correct responses above.

_____Seconds of Arc

OR

_____% Shepard-Fry

PERIPHERAL VISION

Right	***Left***
Temporal_____° Normal: 70-90° **Total**_____° Nasal_____° Normal: 30-60°	Temporal_____° Normal: 70-90° **Total**_____° Nasal_____° Normal: 30-60°

VISUAL ACUITY TESTING

1. Does the selectee wear soft contact lenses (SCLs)?
   - ☐ Yes
   - ☐ No
2. If yes, has the selectee successfully worn SCLs for at least six months?
   - ☐ Yes (If yes, test CORRECTED vision only)
   - ☐ No (If no, test UNCORRRCTED and CORRECTED vision)

(GLASSES/CONTACT LENSES MUST BE REMOVED WHEN TESTING UNCORRECTED VISION)

UNCORRECTED VISION (Snellen Units)	***CORRECTED VISION (Snellen Units)***
FAR Both 20/___ Right 20/___Left 20/___ **NEAR** Both 20/___ Right 20/___ Left 20/____	**FAR** Both 20/____Right 20/___Left 20/____ **NEAR** Both 20/___ Right 20/____Left 20/____

COLOR VISION-HARDY, RAND, AND RITTLER (HRR)

If near visual acuity is 20/30 or better without corrective lenses, then color vision testing should be conducted without corrective lenses

Number of Correct Responses _____ of _____ **(ATTACH HRR COLOR VISION SCORE SHEET)**

Printed Name of Examiner	Signature of Examiner	Date	Telephone Number

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

AUDIOLOGY
(Examiner to complete This Section)

DO NOT TEST WITH HEARING AIDS

Right Ear

Canal/external ear: ☐ Normal ☐ Abnormal (if abnormal, describe)

Tympanic/membrane: ☐ Normal ☐ Abnormal (if abnormal, describe)

Left Ear

Canal/external ear: ☐ Normal ☐ Abnormal (if abnormal, describe)

Tympanic/membrane: ☐ Normal ☐ Abnormal (if abnormal, describe)

Daily Calibration Method: ☐ Oscar (machine) ☐ Biological (person)

Yearly Calibration Date:

Frequency	**500 Hz**	**1000 Hz**	**2000 Hz**	**3000 Hz**	**4000 Hz**	**6000 Hz**
Right Ear						
Left Ear						

BODY MEASUREMENTS
(Examiner to Complete This Section)

Height:_____inches (without shoes)

Weight:_____pounds (without shoes)

VITAL SIGNS
(Examiner to Complete This Section)

Readings	**Pulse**	**Blood Pressure**
Initial Reading		
Repeat Reading	If initial pulse ≥ 100; wait 15 minutes and recheck	If initial BP ≥ 140/90; wait 15 minutes and recheck

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

ORTHOPEDIC CLINICAL EVALUATION
(Examiner to Complete this Section)

Check each item in appropriate column	Normal (No)	Abnormal (Yes)
Upper extremities		
Shoulder, Elbow, Wrist		
Range of motion/flexibility		
Strength/Stability		
Tenderness to palpation		
Pain with motion		
Hand/Fingers		
Range of motion/flexibility		
Strength/Stability		
Tenderness to palpation		
Pain with motion		
Hand Dexterity		

Check each item in appropriate column	Normal (No)	Abnormal (Yes)
Lower Extremities		
Hip, Knee, Ankle, Feet		
Range of motion/flexibility		
Strength/Stability		
Tenderness to palpation		
Pain with motion		
Spine		
Upper Back/Neck		
Range of motion/flexibility		
Strength/Stability		
Tenderness to palpation		
Pain with motion		
Low Back		
Range of motion/flexibility		
Strength/Stability		
Tenderness to palpation		
Pain with motion		

**** EXPLAIN **ALL** ABNORMAL ORTHOPEDIC FINDINGS FOUND ABOVE ON PAGE 11 AND 12 (USE ADDITIONAL PAGES IF NEEDED)*

Functional Screening Evaluation
(Examiner to Complete this Section)

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

(Examiner to Complete This Section)

If ANY orthopedic injury or condition has occurred, document the following for each injury. Use additional paper if necessary.

Issue #1: Type of injury/condition (back strain, ankle sprain, carpal tunnel, etc.): _____

- How did the injury/condition occur?
- Date of injury/diagnosis
- Describe treatment, including approximate dates
- Did the selectee lose time from work/school?
- Have all symptoms resolved? If so, when? If not, describe current symptoms, frequency, and when they occur.
- Does the selectee report any current restrictions or limitations because of this issue? If so, describe.
- Does the selectee report any residual symptoms with exercise (e.g., pain, swelling, exercise intolerance, etc.)?
- Additional comments:
- Based on your physical exam, does the selectee appear to have limitations because of this issue? ☐ Yes ☐ No

Issue #2: Type of injury/condition (back strain, ankle sprain, carpal tunnel, etc.): _____

- How did the injury/condition occur?
- Date of injury/diagnosis
- Describe treatment, including approximate dates
- Did the selectee lose time from work/school?
- Have all symptoms resolved? If so, when? If not, describe current symptoms, frequency, and when they occur.
- Does the selectee report any current restrictions or limitations because of this issue? If so, describe.
- Does the selectee report any residual symptoms with exercise (e.g., pain, swelling, exercise intolerance, etc.)?
- Additional comments:
- Based on your physical exam, does the selectee appear to have limitations because of this issue? ☐ Yes ☐ No

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

(Examiner to Complete This Section)

If ANY orthopedic injury has occurred, document the following for each injury. Use additional paper if necessary.

Issue #3: Type of injury/condition (back strain, ankle sprain, carpal tunnel, etc.): _____

- How did the injury/condition occur?
- Date of injury/diagnosis
- Describe treatment, including approximate dates
- Did the selectee lose time from work/school?
- Have all symptoms resolved? If so, when? If not, describe current symptoms, frequency, and when they occur.
- Does the selectee report any current restrictions or limitations because of this issue? If so, describe.
- Does the selectee report any residual symptoms with exercise (e.g., pain, swelling, exercise intolerance, etc.)?
- Additional comments:
- Based on your physical exam, does the selectee appear to have limitations because of this issue? ☐ Yes ☐ No

Issue #4: Type of injury/condition (back strain, ankle sprain, carpal tunnel, etc.): _____

- How did the injury/condition occur?
- Date of injury/diagnosis
- Describe treatment, including approximate dates
- Did the selectee lose time from work/school?
- Have all symptoms resolved? If so, when? If not, describe current symptoms, frequency, and when they occur.
- Does the selectee report any current restrictions or limitations because of this issue? If so, describe.
- Does the selectee report any residual symptoms with exercise (e.g., pain, swelling, exercise intolerance, etc.)?
- Additional comments:
- Based on your physical exam, does the selectee appear to have limitations because of this issue? ☐ Yes ☐ No

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

CLINICAL EVALUATION
(Examiner to Complete this Section)

Check each item in appropriate column	Normal	Abnormal
Head, face, neck, and scalp (include thyroid)		
Nose		
Sinuses		
Mouth and throat		
Ears-General, ear drums		
Eyes, General, pupils, ocular, motility, nystagmus		
Heart (rhythm, sounds, murmur)		
EKG Interpretation		
Lungs and chest		
Vascular System (Varicosities)		
Abdomen and viscera		
Hernia		
Identifying body marks, scars, unique markings other than tattoos		
Skin, lymphatics		
Neurologic		

*****NOTE **ALL** ABNORMAL FINDINGS BELOW*

PHYSICIAN/NP/PA'S SUMMARY OF SIGNIFICANT MEDICAL FINDINGS AND RECOMMENDATIONS

NOTES: *Describe every abnormality if not already described on previous page(s). Describe in detail, based on history, and exam. Use additional sheets if necessary.*

I have reviewed and discussed the medical history with the selectee. Based on my review of the physical examination findings, to include blood pressure and EKG interpretation, it is my opinion that the selectee is CLEARED to complete the fitness step test.

□ YES □ No (If no, explain above)

NAME OF EXAMINING PHYSICIAN/NP/PA: (Please print or type.) ☐ **MD** ☐ **DO** ☐ **NP** ☐ **PA (requires co-signature)**

PHYSICIAN/NP/PA'S SIGNATURE: **DATE:**

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

SELECTEE AND EXAMINER COMMENTS

(Selectee and Examiner to Complete This Section)

For all "yes" answers from prior pages, explain in detail. Use additional sheets if needed.

SELECTEE			EXAMINER
Question Number	Date of Injury/Date of Diagnosis (month/year)	Explain in detail the diagnosis, how injury/illness occurred, symptoms, body part affected, type of treatment, current symptoms, etc.	Examiner's Comments

ICE Pre-Employment *Tuberculosis Symptom Screening Questionnaire*

This form is to be used in lieu of TB screening testing for pre-employment. Examiners must ensure that individuals under consideration for a position with ICE are free of highly contagious diseases, such as active tuberculosis, that could endanger the health of other persons.

Part A should be completed by the individual. A healthcare professional must evaluate the answers and assign a recommendation in Part B.

PART A

1. Have you experienced any of the following symptoms in the past year?

a.) A productive cough for more than 3 weeks?	Yes	No
b.) Hemoptysis (coughing up blood)?	Yes	No
c.) Unexplained weight loss?	Yes	No
d.) Fever, Chills, or night sweats for no known reason?	Yes	No
e.) Persistent shortness of breath?	Yes	No
f.) Unexplained fatigue?	Yes	No
g.) Chest Pain?	Yes	No

2. Have you had contact with anyone with active tuberculosis disease in the past year? Yes No

3) Do you have a medical condition, or are you taking medications, which suppress your immune system? Yes No

Please provide details to any question answered "Yes".

I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.

Signature Printed Name Date

PART B

Upon review of the responses to the questionnaire and discussion with the person for whom the tuberculosis evaluation is required, I recommend as follows:

_____There is no indication this person has active tuberculosis at this time.
_____ Examiner notes regarding any "YES" responses:

_____ Further evaluation, including a TB Skin Test or other medical evaluation is indicated, and should be completed prior to employment.

_____ _____ _____
Healthcare Professional Signature Printed Name Date