U. S. Coast Guard - Scientific Mission Personnel Data Sheet - MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

PRIVACY ACT STATEMENT

AUTHORITY: 10USC 504, 505, 507, 532, 978, 1201, 1202 and 4346; and e.o. 9397.

PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness, & facilitate treatment.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application.

Forms must be received **no later than three (3) months prior to embarkation.**
You are encouraged to get a receipt acknowledgement from the Exective Officer at the above email address.

When completed use one of the following methods to return your form:
EMAIL (preferred): D13-DG-CGCHEALY-Medical@USCG.MIL
US MAIL: Medical Officer, USCGC HEALY (WAGB 20), 1519 Alaskan Way S, Seattle WA 98134
Note: Mailed forms must arrive before the ship gets underway from Seattle, WA. Due to limited US Mail availablity while deployed, forms submitted via US Mail MUST arrive prior to HEALY's departure, irregardless of your embarkation date.

Note: All personnel, **62** years of age and older, are also required to submit a physical exam conducted within the previous 12 months as outlined in the Medical Screening for Embarking Civilian Personnel, HEALYINST 6100.B. Please contact the HEALY Medical Officer at the above e-mail address for direction on how to submit your physical exam information.

The information submitted will be confidential, and all forms will be destroyed once the person departs.

Mission Number:	**TODAY'S DATE:**
LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	**Emergency Contact (Last Name, First Name, MI):**
HOME ADDRESS (Street, Apartment No., City, State & ZIP Code)	**Emergency Contact Address:**
Phone Number:	**Emergency Contact Telephone (Include Area Code):**
Date of Birth:	
Sex (M/F):	**Family Doctor:**
Present Health: Excellent ☐ Good ☐ Fair/Poor* ☐	**Address:**
***if Fair/Poor must make comment on next page**	**Telephone Nr:**

CURRENT MEDICATIONS (Prescription and Over-the-Counter, including herbals & supplements)	**LIST ALL CHRONIC MEDICAL CONDITIONS**

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Comments next page.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
Tuberculosis		
Lived with someone who had tuberculosis		
Coughed up blood		
Asthma or any breathing problems		
Shortness of breath		
Bronchitis		
Wheezing or problems with wheezing		
A chronic cough or cough at night		
Sinusitis		
Allergies/Hay fever		
Chronic or frequent colds		
Severe tooth or gum trouble		
Thyroid trouble or goiter		
Eye disorder or trouble		
Ear, nose or throat trouble		
Loss of vision in either eye		

(Continued)	YES	NO
Foot trouble (e.g., pain, corn, bunions, etc.)		
Impaired use of arms, legs, hands or feet		
Swollen or painful joint(s)		
Knee trouble of any kind		
Any knee or foot surgery		
Any need for corrective devices, braces, etc.		
Bone, joint or other deformity		
Plate(s), screw(s), rod(s) or pin(s) in any bone		
Broken bone(s), cracked or fractured		
Frequent indigestion or heartburn		
Stomach, liver, intestinal trouble or ulcer		
Gallbladder trouble or gallstones		
Jaundice or hepatitis (live disease)		
Rupture/hernia		
Rectal disease, hemorrhoids or blood at rectum		
Skin diseases (e.g. acne, eczema, etc.)		
Frequent or painful urination		
High or low blood sugar		

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Comments next page.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
Painful shoulder, elbow or wrist		
Arthritis, rheumatism or bursitis		
Recurrent back pain or any back problem		
Numbness or tingling		
Dizziness or fainting spells		
A stroke, TIA, or a "mini stroke"		
Frequent or severe headache		
A head injury, memory loss or amnesia		
Paralysis		
Seizures, convulsions, epilepsy or fits		
Car, train, sea or air sickness		
A period of unconsciousness or concussion		
Meningitis, encephalitis or other neurologic problem		
Prolonged bleeding (such as after surgery, etc.)		
Pain or pressure in the chest		
Palpitation, pounding heart or abnormal heartbeat		
Heart trouble or murmur		
Had a heart attack, stent, or bypass		
Been prescribed blood thinners		
High or low blood pressure		
Nervous trouble of any sort (anxiety or panic attacks)		
Loss of memory or amnesia, or neurologic problems		
Frequent trouble sleeping		
Received counseling of any type		
Depression or excessive worry		
Been evaluated or treated for a mental condition		
Attempted suicide		
Been a sleepwalker or been told you sleepwalk		
Suffered from hallucinations		
Been diagnosed with Bipolar Disorder		
Used illegal drugs or abused prescription drugs		

	YES	NO
Adverse reaction to serum, food, insects or medicine		
Tumor, growth, cyst or cancer		
Have you ever been treated in the Emergency Room?		
Have you ever been a patient in a hospital?		
Have you ever had, or have you been advised to have any operations or surgery?		

	YES	NO
Have you had the following immunizations:		
Hepatitis A		
Hepatitis B		
Influenza date of last shot:		
Tetanus date of last shot:		
Have you ever had any illness or injury other than those already noted?		
Do you have any allergies to medicine, food or latex gloves? (If yes, see amp info below)		

DENTAL

Last Exam:

	YES	NO
Any dental conditions needing treatment within the next 12 months?		
Do you have any current dental pain or gum swelling?		

EXPLANATION TO ANY 'YES' ANSWERS:

IMPORTANT: Due to the missions performed by HEALY crew and passengers and the locations to which HEALY travels, falsifying or concealing medical information may place you, the crew, and other passengers in **SERIOUS DANGER**. It is therefore IMPERATIVE that this form be as complete and accurate as possible.

If you answered “yes” to food or medication allergy, please provide the food/medication to which you are allergic **and the reaction you experience if exposed:**

Explain **ALL** other "Yes" answers:

Please list **ANY** special dietary needs:

Do you have an advanced directive (Do-Not-Resuscitate order, living will, etc.)? If "Yes," please specify: