

Medical History Questionnaire

Appendix G

Revision 01, April 2004

ENVIRONMENTAL PROTECTION AGENCY

LAKE GUARDIAN

SURVEY PERSONNEL DATA SHEET

Date: _____

This form has been designed to obtain information necessary in the event of an emergency while preserving an individual's privacy. In the interest of your personal safety and well being, it is vital that someone aboard be aware of any significant medical condition that you may have. All information provided will be kept confidential. Thank you for your cooperation.

Name: _____ Phone: _____

Home Address: _____

Mailing Address: _____

Rating: _____ License Held: _____ Z or License No.: _____

SS#: _____ Date of Birth: _____ Place: _____

Blood Type: _____ Medic Alert Tag? (Y/N): _____ Last Tetanus Shot: _____

Physician's Name: _____ Phone #: _____

Date and Place of Last Physical Exam: _____

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Contact Lenses (Y/N): _____ Scars or Marks: _____

In Case of Emergency, Notify:

Name: _____ Relationship: _____

Phone Number: _____

Please circle appropriate response(s) and comment.

Do you have known heart disease, attack or stroke: by-pass surgery or other type of heart surgery?

Do you have insulin or non-insulin dependent diabetes? _____

Do you have high blood pressure? Your typical blood pressure reading? _____

Do you have allergies? (Specify): _____

Do you have any current history of thyroid, kidney, liver, lung diseases, seizures, cancer, pregnancy, bleeding, etc? _____

Do you currently have any of the following: chest pain, or pressure, shortness of breath, irregular heart beat, dizziness, other? _____

Do you have any problems with bones, muscles, back, neck? _____

Current medication(s) and dosage? _____

MEDICAL HISTORY

This form has been designed to obtain information necessary in the event of an emergency while preserving an individual's privacy. In the interest of your personal safety and well being, it is vital that someone aboard be aware of any significant medical condition that you may have, which may require the knowledgeable action of someone on-board to assist you. All information provided will be kept confidential. Thank you for your cooperation.

Your typical Blood Pressure Reading: _____

Current Medication(s): _____

Allergies: _____

Medical History:

Please circle one of the responses for any of the following medical conditions you currently have or have had in the past (specify).

CARDIOVASCULAR

High Blood Pressure	YES	NO
Heart Attack	YES	NO
Coronary Artery Disease	YES	NO
Mitral Valve Prolapsed	YES	NO
Heart Murmur	YES	NO
Stroke	YES	NO
Aneurysm.....	YES	NO
Coronary bypass or any other type of heart surgery	YES	NO
Other Cardiovascular Disease (Specify):		

COMMENTS

RESPIRATORY

Asthma	YES	NO
Emphysema.....	YES	NO
Bronchitis.....	YES	NO
Tuberculosis.....	YES	NO
Collapsed Lung	YES	NO
Lung Surgery	YES	NO
Other Lung Disease (Specify):		

COMMENTS

NEUROLOGICAL

Migraine Headaches	YES	NO
Seizures	YES	NO
Head Injury	YES	NO
Spinal Cord Injury	YES	NO
Head/Spine Surgery	YES	NO
Other Neurological Disease (Specify):		

COMMENTS

MUSCULOSKELETAL.....

Gait Abnormalities.....	YES	NO
Loss of function of extremity.....	YES	NO
Back/Neck Pain.....	YES	NO

COMMENTS

Other (Specify):

OTHER SIGNIFICANT MEDICAL CONDITIONS: ..

COMMENTS

Bleeding disorder	YES	NO
Cancer History	YES	NO
Claustrophobia	YES	NO
Diabetes (specify insulin or non-insulin) dependent	YES	NO
Hepatitis/Liver Disease	YES	NO
Kidney Disease	YES	NO
Psychiatric illness	YES	NO
Thyroid Disease	YES	NO
Pregnancy	YES	NO
Other (Specify):		

COMMENTS:

Please indicate if you have any of the following sign or symptoms:

COMMENTS

Fever	YES	NO
Generalized weakness	YES	NO
Unexplained weigh loss/gain	YES	NO
Change in vision	YES	NO
Nosebleeds	YES	NO
Difficulty hearing.....	YES	NO
Chest pain or pressure.....	YES	NO
Irregular heart beat.....	YES	NO
Palpitations.....	YES	NO
Cough.....	YES	NO
Wheezing	YES	NO
Shortness of breath.....	YES	NO
Nausea / vomiting	YES	NO
Rectal bleeding or black tarry stools.....	YES	NO
Dizziness	YES	NO
Loss of consciousness	YES	NO
Panic attacks	YES	NO
Numbness or tingling.....	YES	NO
Other (Specify):		
