

OCCUPATIONAL HEALTH SCREENING FORM

Reason for Visit:

Date:

Patient Information				
Name	DOB	DoD ID or Full SSN:		
Organization/Program		Job Title & Job Series		
Work Number		Cell Number:		
Email:	Supervisor:	Supervisor's Phone:		
Personal medical history (check all that apply)				
☐ No known medical conditions ☐ Allergies (Drug, Food, Environmental) ☐ Anemia ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Autoimmune Disorder (Specify: _____) ☐ Cancer (Specify: _____) ☐ Congestive heart failure ☐ COPD / Emphysema ☐ Depression ☐ Diabetes (Type 1 / Type 2) ☐ Epilepsy / Seizures ☐ GERD (Acid Reflux) ☐ Glaucoma ☐ Gout ☐ Heart Attack / Heart Disease ☐ High Blood Pressure (Hypertension) ☐ High Cholesterol ☐ HIV/AIDS ☐ Kidney Disease / Kidney Stones ☐ Liver Disease / Hepatitis ☐ Migraines ☐ Osteoporosis ☐ Sleep Apnea ☐ Sleep: Insomnia/Difficulties ☐ Stroke ☐ Substance Abuse (Alcohol / Drugs) ☐ Thyroid Disease (Hypo / Hyper) ☐ Tuberculosis ☐ Ulcers				
Other medical issues:				
Medications				
Name(s)	Dosage(s)	Frequency	Reason for Taking	Note(s)
Medication Allergies/Reaction Name of Medication(s): ☐ No medication allergies Reaction(s):				
Allergy to Latex: Yes ☐ No ☐ If yes, reaction:				

Surgeries (site and date)		
Social history		
Factor	Check one	Most recent date (if applicable)
Tobacco Use	☐ Cigarettes ☐ Cigars ☐ Chew/Dip ☐ Vape ☐ Quit ☐ Never Used	
Alcohol Use	☐ Occasional ☐ Moderate ☐ Heavy ☐ Don't Drink	
Caffeine (Coffee, Tea, Soda, Energy Drinks)	☐ No ☐ Yes (amount per day)	
Pre/Post Workout Supplements	☐ No ☐ Yes [] Times per week	
Exercise Routine	[] Times per week	
Sleep	[] Hours a night	
Living Situation: ☐ With roommates ☐ With S/O ☐ With family ☐ Other:		
Additional Notes <i>By providing my name (full name: first and last), date of birth (DOB) and today's date, I hereby certify that, to the best of my knowledge, the above provided information is true and accurate.</i> Patient name: _____ DOB: _____ Date: _____		
Staff Section: Vitals: Height: _____ Weight: _____ BMI: _____ BP: _____ HR: _____ Resp: _____ Temp: _____ O2Sat: _____ Repeat vitals: Nurses Notes: Providers Notes: 		

Fox Army Health Center

MCXW-OH

Hearing Program Questionnaire									
Last name			First name			DOB			
SSN			Phone			Rank/Grade			
MOS/Job code			Unit						
Branch/DoD (choose one)									
	Army		Navy		Coast Guard		Air Force		
	Marines		Cadet/ROTC		Civilian		Foreign National		
Service Component (choose one)									
	Active Duty			National Guard			Reserves		
Reason for Hearing Test (choose one)									
	Annual		Pre-employment		Pre-deployment		Retirement/ETS		
	Flight class		PCMH referral		Other:				
Are you bothered by ringing in the ears?									
	Not bothered at all			Bothered a little			Bothered a lot		
What type of hearing protection do you use?									
Do you wear hearing aids?									
Have you been exposed to loud noise within the last 14 hours?									
Have you returned from a deployment in the past 6 months?									
Any history of blast noise exposure?									
Any history of hearing loss?									
Have you seen an audiologist recently?									
Date of audiology appointment:									

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

This form is not an authorization or consent to use or disclose your health information.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):

10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. Chapter 55, Medical and Dental Care; 42 U.S.C. Chapter 32, Third Party Liability for Hospital and Medical Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); DoDI 6055.05, Occupational and Environmental Health (OEI); and E.O. 9397 (SSN), as amended.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED:

Information may be collected from you to provide and document your medical care; determine your eligibility for benefits and entitlements; adjudicate claims; determine whether a third party is responsible for the cost of Military Health System (MHS) provided healthcare and recover that cost; evaluate your fitness for duty and medical concerns which may have resulted from an occupational or environmental hazard; evaluate the MHS and its programs; and perform administrative tasks related to MHS operations and personnel readiness.

3. ROUTINE USES:

Information in your records may be disclosed to:

- Private physicians and Federal agencies, including the Department of Veterans Affairs, Health and Human Services, and Homeland Security (with regard to members of the Coast Guard), in connection with your medical care;
- Government agencies to determine your eligibility for benefits and entitlements;
- Government and nongovernment third parties to recover the cost of MHS provided care;
- Public health authorities to document and review occupational and environmental exposure data; and
- Government and nongovernment organizations to perform DoD-approved research.

Information in your records may be used for other lawful reasons which may include teaching, compiling statistical data, and evaluating the care rendered. Use and disclosure of your records outside of DoD may also occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: <http://dpcl.d.defense.gov/privacy/SORNsIndex/BlanketRoutineUses.aspx>.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION:

Voluntary. If you choose not to provide the requested information, comprehensive health care services may not be possible, you may experience administrative delays, and you may be rejected for service or an assignment. However, care will not be denied.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by MHS health care treatment personnel or for medical/dental treatment purposes and is intended to become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

5. SIGNATURE OF PATIENT OR SPONSOR

6. SOCIAL SECURITY NUMBER OR
DOD IDENTIFICATION NUMBER
OF MEMBER OR SPONSOR

7. DATE (YYYYMMDD)

INITIAL ENTRY TUBERCULOSIS (TB) RISK ASSESSMENT TOOL

For use of this form see, MEDCOM Reg 40-64, the proponent agency is MCPO-SA

INITIAL ENTRY Tuberculosis (TB) Risk Assessment Tool		REVIEWER INSTRUCTION
1. Have you ever had face-to-face contact with someone who was sick with tuberculosis (TB)?	☐ Yes ☐ No	
2. Were you born outside the United States? If yes, list country: _____	☐ Yes ☐ No	
3. Did you ever live with a family member that was born outside the United States? If yes, list country: _____	☐ Yes ☐ No	
4. Have you ever had a positive TB test, prior diagnosis of TB, or prior treatment for TB?	☐ Yes ☐ No	
If "NO" answers = low risk → STOP. Any "YES" answers = increase risk → Go to question #5		If all "NO" responses, Then do not test
5. Do you have any of the following symptoms of tuberculosis? Cough > 2 weeks, fever > 2 weeks, drenching night sweats, or unplanned weight loss?	☐ Yes ☐ No	
If "YES" → STOP. Any "NO" → Go to question #6		If "YES" then refer immediately to provider for evaluation of TB disease.
6. Do you have documentation of previous TB treatment with you today?	☐ Yes ☐ No STOP.	
Reviewer comments		If "YES" → Do NOT test. Document exemption in MEDPROS If "NO" → Test for TB. Note: If "Yes" response only to Question 2 or 3 above, testing is only required if the country is Listed on the reverse side.
PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last-first-middle; DOB; SSN; date; hospital or medical facility) NAME: DOB: SS#: DATE:	REVIEWER NAME	REVIEWER SIGNATURE

The following countries, if documented on the TB Risk Assessment Tool, indicate need for patient to be tested:

Afghanistan	Egypt	Malaysia	Senegal
Algeria	El Salvador	Maldives	Serbia
Angola	Equatorial Guinea	Mali	Serbia & Montenegro
Anguilla	Eritrea	Marshall Islands	Seychelles
Argentina	Estonia	Mauritania	Sierra Leone
Armenia	Ethiopia	Mauritius	Singapore
Azerbaijan	Fiji	Micronesia – Fed States	Solomon Islands
Bahrain	French Polynesia	Moldova	Somalia
Bangladesh	Gabon	Mongolia	South Africa
Belarus	Gambia	Montenegro	Sri Lanka
Belize	Georgia	Montserrat	Sudan
Benin	Ghana	Morocco	Suriname
Bhutan	Guam	Mozambique	Swaziland
Bolivia	Guatemala	Myanmar	Syrian Arab Republic
Bosnia & Herzegovina	Guinea	N. Mariana Islands	Tajikistan
Botswana	Guinea – Bissau	Namibia	Tanzania-UR
Brazil	Guyana	Nauru	Thailand
British Virgin Islands	Haiti	Nepal	Timor-Leste
Brunei Darussalam	Honduras	New Caledonia	Togo
Bulgaria	India	Nicaragua	Tonga
Burkina Faso	Indonesia	Niger	Trinidad & Tobago
Burundi	Iran	Nigeria	Tunisia
Cambodia	Iraq	Pakistan	Turkey
Cameroon	Japan	Palau	Turkmenistan
Cape Verde	Kazakhstan	Panama	Turks & Caicos Islands
Central African Republic	Kenya	Papua New Guinea	Tuvalu
Chad	Kiribati	Paraguay	Uganda
China	Korea – DR	Peru	Ukraine
China, Hong Kong SAR	Korea – Rep of	Philippines	Uruguay
China, Macao SAR	Kuwait	Poland	Uzbekistan
Colombia	Kyrgyzstan	Portugal	Vanuatu
Comoros	Lao PDR	Qatar	Venezuela
Congo	Latvia	Romania	Viet Nam
Congo – DR	Lesotho	Russian Federation	Wallis & Futuna Islands
Cook Islands	Liberia	Rwanda	West Bank & Gaza Strip
Cote d'Ivoire	Libya	St. Vincent & Grenadines	Yemen
Croatia	Lithuania	Samoa	Zambia
Djibouti	Macedonia	Sao Tome & Principe	Zimbabwe
Dominican Republic	Madagascar	Saudi Arabia	
Ecuador	Malawi		

REPORT OF MEDICAL HISTORY (This information is for official and medically confidential use only and will not be released to unauthorized persons.)				OMB No. 0704-0413 OMB approval expires Oct 31, 2017	
The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Directives Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (0704-0413). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.					
PRIVACY ACT STATEMENT					
AUTHORITY: 10 U.S.C. 136, DoD Instruction 6130.03, and E.O. 9397, as amended (SSN). PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted on the prescreening form (DD 2807-2). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted. Completed forms are covered by recruiting, medical evaluation board, and official military personnel file SORNs maintained by each of the Services. ROUTINE USE(S): The Blanket Routine Uses found at http://dpcl.dod.mil/Privacy/SORNsIndex/BlanketRoutineUses.aspx apply to this collection. DISCLOSURE: Voluntary. However, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.					
WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.					
1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)		2. SOCIAL SECURITY NUMBER		3. TODAY'S DATE (YYYYMMDD)	
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)		5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)			
b. HOME TELEPHONE (Include Area Code)		Fox Army Health Center 4100 Goss Road Redstone Arsenal, AL 35809-7000			
X ALL APPLICABLE BOXES:				7.a. POSITION (Title, Grade, Component)	
6.a. SERVICE ☐ Army ☐ Coast Guard ☐ Navy ☐ Marine Corps ☐ Air Force		6.b. COMPONENT ☐ Regular ☐ Reserve ☐ National Guard		6.c. PURPOSE OF EXAMINATION ☐ Enlistment ☐ Medical Board ☐ Other (Specify) ☐ Commission ☐ Retirement ☐ Retention ☐ U.S. Service Academy ☐ Separation ☐ ROTC Scholarship Program	
8. CURRENT MEDICATIONS (Prescription and Over-the-counter)		7.b. USUAL OCCUPATION			
9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)					
Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.					
HAVE YOU EVER HAD OR DO YOU NOW HAVE:				12. (Continued)	
10.a. Tuberculosis				f. Foot trouble (e.g., pain, corns, bunions, etc.)	
b. Lived with someone who had tuberculosis				g. Impaired use of arms, legs, hands, or feet	
c. Coughed up blood				h. Swollen or painful joint(s)	
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.				i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	
e. Shortness of breath				j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	
f. Bronchitis				k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	
g. Wheezing or problems with wheezing				l. Bone, joint, or other deformity	
h. Been prescribed or used an inhaler				m. Plate(s), screw(s), rod(s) or pin(s) in any bone	
i. A chronic cough or cough at night				n. Broken bone(s) (cracked or fractured)	
j. Sinusitis				13.a. Frequent indigestion or heartburn	
k. Hay fever				b. Stomach, liver, intestinal trouble, or ulcer	
l. Chronic or frequent colds				c. Gall bladder trouble or gallstones	
11.a. Severe tooth or gum trouble				d. Jaundice or hepatitis (liver disease)	
b. Thyroid trouble or goiter				e. Rupture/hernia	
c. Eye disorder or trouble				f. Rectal disease, hemorrhoids or blood from the rectum	
d. Ear, nose, or throat trouble				g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	
e. Loss of vision in either eye				h. Frequent or painful urination	
f. Worn contact lenses or glasses				i. High or low blood sugar	
g. A hearing loss or wear a hearing aid				j. Kidney stone or blood in urine	
h. Surgery to correct vision (RK, PRK, LASIK, etc.)				k. Sugar or protein in urine	
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)				l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	
b. Arthritis, rheumatism, or bursitis				14.a. Adverse reaction to serum, food, insect stings or medicine	
c. Recurrent back pain or any back problem				b. Recent unexplained gain or loss of weight	
d. Numbness or tingling				c. Currently in good health (If no, explain in Item 29 on Page 2.)	
e. Loss of finger or toe				d. Tumor, growth, cyst, or cancer	

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.	
HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES NO
15.a. Dizziness or fainting spells	☐ YES ☐ NO
b. Frequent or severe headache	☐ YES ☐ NO
c. A head injury, memory loss or amnesia	☐ YES ☐ NO
d. Paralysis	☐ YES ☐ NO
e. Seizures, convulsions, epilepsy or fits	☐ YES ☐ NO
f. Car, train, sea, or air sickness	☐ YES ☐ NO
g. A period of unconsciousness or concussion	☐ YES ☐ NO
h. Meningitis, encephalitis, or other neurological problems	☐ YES ☐ NO
16.a. Rheumatic fever	☐ YES ☐ NO
b. Prolonged bleeding (<i>as after an injury or tooth extraction, etc.</i>)	☐ YES ☐ NO
c. Pain or pressure in the chest	☐ YES ☐ NO
d. Palpitation, pounding heart or abnormal heartbeat	☐ YES ☐ NO
e. Heart trouble or murmur	☐ YES ☐ NO
f. High or low blood pressure	☐ YES ☐ NO
17.a. Nervous trouble of any sort (<i>anxiety or panic attacks</i>)	☐ YES ☐ NO
b. Habitual stammering or stuttering	☐ YES ☐ NO
c. Loss of memory or amnesia, or neurological symptoms	☐ YES ☐ NO
d. Frequent trouble sleeping	☐ YES ☐ NO
e. Received counseling of any type	☐ YES ☐ NO
f. Depression or excessive worry	☐ YES ☐ NO
g. Been evaluated or treated for a mental condition	☐ YES ☐ NO
h. Attempted suicide	☐ YES ☐ NO
i. Used illegal drugs or abused prescription drugs	☐ YES ☐ NO
18. FEMALES ONLY. Have you ever had or do you now have:	☐ YES ☐ NO
a. Treatment for a gynecological (female) disorder	☐ YES ☐ NO
b. A change of menstrual pattern	☐ YES ☐ NO
c. Any abnormal PAP smears	☐ YES ☐ NO
d. First day of last menstrual period (YYYYMMDD)	☐ YES ☐ NO
e. Date of last PAP smear (YYYYMMDD)	☐ YES ☐ NO
19. Have you been refused employment or been unable to hold a job or stay in school because of:	☐ YES ☐ NO
a. Sensitivity to chemicals, dust, sunlight, etc.	☐ YES ☐ NO
b. Inability to perform certain motions	☐ YES ☐ NO
c. Inability to stand, sit, kneel, lie down, etc.	☐ YES ☐ NO
d. Other medical reasons (<i>If yes, give reasons.</i>)	☐ YES ☐ NO
20. Have you ever been treated in an Emergency Room? (<i>If yes, for what?</i>)	☐ YES ☐ NO
21. Have you ever been a patient in any type of hospital? (<i>If yes, specify when, where, why, and name of doctor and complete address of hospital.</i>)	☐ YES ☐ NO
22. Have you ever had, or have you been advised to have any operations or surgery? (<i>If yes, describe and give age at which occurred.</i>)	☐ YES ☐ NO
23. Have you ever had any illness or injury other than those already noted? (<i>If yes, specify when, where, and give details.</i>)	☐ YES ☐ NO
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (<i>If yes, give complete address of doctor, hospital, clinic, and details.</i>)	☐ YES ☐ NO
25. Have you ever been rejected for military service for any reason? (<i>If yes, give date and reason for rejection.</i>)	☐ YES ☐ NO
26. Have you ever been discharged from military service for any reason? (<i>If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.</i>)	☐ YES ☐ NO
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (<i>If yes, specify what kind, granted by whom, and what amount, when, why.</i>)	☐ YES ☐ NO
28. Have you ever been denied life insurance?	☐ YES ☐ NO
29. EXPLANATION OF "YES" ANSWER(S) (<i>Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.</i>)	

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

