UHMS MEDICAL HISTORY FORM

Employer	Job Title	Date

1. Last Name / First Name / Middle Name	2. Date of Birth	3. Gender	4. SSN

5. Address (Number, Street) / 6. City	7. State	8. Zip Code	9. Area Code – Phone Number
			( )

10. Emergency Contact Person – Relationship – Address – Telephone Number	11. Cell Phone Number
	( )

12. MEDICAL HISTORY: Have you ever had or been treated for (positive answers must be explained below):

Yes	No		Yes	No		Yes	No	
☐	☐	Convulsions or Seizures	☐	☐	Cardiac Angiogram or ECHO	☐	☐	Herniated Disc or Sciatica
☐	☐	Epilepsy	☐	☐	PFO Repair	☐	☐	Shoulder Injury
☐	☐	Concussion or Head Injury	☐	☐	High Blood Pressure	☐	☐	Elbow Injury
☐	☐	Disabling Headaches	☐	☐	Asthma or Wheezing	☐	☐	Arm/wrist/hand Injury
☐	☐	Loss of Balance/Dizziness	☐	☐	Coughing up Blood	☐	☐	Hip/Leg/Ankle Injury
☐	☐	Severe Motion Sickness	☐	☐	Tuberculosis	☐	☐	Knee Injury or "Trick Knee"
☐	☐	Unconsciousness	☐	☐	Shortness of Breath	☐	☐	Foot Trouble or Injuries
☐	☐	Fainting Spells	☐	☐	Chronic Cough	☐	☐	Dislocations
☐	☐	Wear Contacts/Glasses	☐	☐	Pneumothorax	☐	☐	Swollen Joints
☐	☐	Color Vision Defect	☐	☐	Lung Disease or Surgery	☐	☐	Broken Bones or Fractures
☐	☐	Eye Disease or Injury	☐	☐	Gallbladder Disease or Stones	☐	☐	Varicose Veins
☐	☐	Eye Surgery	☐	☐	Stomach Trouble or Ulcers	☐	☐	Muscle Disease or Weakness
☐	☐	Hearing Loss	☐	☐	Stomach Bleeding	☐	☐	Numbness or Paralysis
☐	☐	Ear Disease or Injury	☐	☐	Frequent Indigestion	☐	☐	Sleep Disorders
☐	☐	Ear Surgery	☐	☐	Jaundice	☐	☐	Diabetes
☐	☐	Perforated Eardrum	☐	☐	Liver Disease or Hepatitis	☐	☐	Goiter or Thyroid Disease
☐	☐	Difficulty Clearing	☐	☐	Rectal Bleeding/Blood in Stools	☐	☐	Blood Disease
☐	☐	Nose Bleed	☐	☐	Hemorrhoids (Piles)	☐	☐	Anemia: Sickle Cell or Other
☐	☐	Airway Obstruction	☐	☐	Gas Pains	☐	☐	Skin Rash or Disease
☐	☐	Hay Fever or Allergies	☐	☐	Crohn's Disease/Ulcerative Colitis	☐	☐	Staph Infections
☐	☐	Chest Pain	☐	☐	Rupture or Hernia	☐	☐	Tumor or Cancer
☐	☐	Heart Murmur	☐	☐	Kidney Disease	☐	☐	Claustrophobia
☐	☐	Rheumatic Fever	☐	☐	Kidney Stones	☐	☐	Mental Illness/Depression/Anxiety
☐	☐	Heart Attack	☐	☐	Protein, Sugar or Blood in Urine	☐	☐	Nervous Breakdown
☐	☐	Abnormal Heart Rhythm	☐	☐	Joint Pain/Arthritis	☐	☐	Any Sexually Transmitted Disease
☐	☐	Heart Disease	☐	☐	Back Strain or Injury	☐	☐	Contagious Disease
☐	☐	Cardiac Stent or Angioplasty	☐	☐	Spine Problems	☐	☐	Other Illness, Injury or Medical Condition
		For Females ONLY	☐	☐	Painful Menses			
☐	☐	Irregular Menses	☐	☐	Pregnancy			Last Menstrual Period _____

PLEASE EXPLAIN THE DETAILS OF EACH ITEM CHECKED YES

13. LIST ALL SURGERIES YEAR

14. LIST ALL HOSPTALIZATIONS YEAR

15. LIST ALL INJURIES YEAR

16. LIST ALL MEDICATIONS, PRESCRIPTION OR OVER THE COUNTER

17. ANSWER THE FOLLOWING QUESTIONS:	YES	NO		YES	NO
Do you have any physical defects or any partial disabilities?			Have you ever resigned, been terminated, or changed jobs for medical reasons?		
Have you ever been rejected or rated for insurance, employment, license, or armed forces for health reasons?			Have you ever been dismissed from employment because of excess use of drugs or alcohol?		
Have you ever had illnesses, injuries, or lost time accidents from any work that you have done?			Do you have any allergies or reactions to food, chemicals, drugs, insect stings, or marine life?		
Have you been advised to have a surgical operation or medical treatment that has not been done?			Are you presently under the care of a physician? Give physician's name and address on the next page.		

COMMENTS:

18. My Personal Physician is:

Name _____
Address _____
City, State _____
Phone Number _____

19. Multiplace Chamber History **How long have you been an inside attendant?** _____

20. DIVING EXPERIENCE (years experience):

Recreational ____
Commercial ____

21. NUMBER OF DECOMPRESSION INCIDENTS

	If none, put 0 (zero)	**List any residuals**
Bends, pain only	____	_____
Bends, neurological	____	_____
Chokes	____	_____
Inner ear	____	_____

22. **IN DIVING HAVE YOU HAD A HISTORY OF: (Provide details of dates and severity)**

	Yes	No	Details		Yes	No	Details
Gas Embolism	☐	☐	_____	Near Drowning	☐	☐	_____
Oxygen Toxicity	☐	☐	_____	Asphyxiation	☐	☐	_____
Ear/Sinus Squeeze	☐	☐	_____	Vertigo (Dizziness)	☐	☐	_____
Ear Drum Rupture	☐	☐	_____	Pneumothorax	☐	☐	_____
Deafness	☐	☐	_____	Nitrogen Narcosis	☐	☐	_____
Lung Squeeze	☐	☐	_____	Loss of Consciousness	☐	☐	_____

23. Have you had any decompression sickness or gas embolism since your last physical examination? Yes ☐ No ☐

Date of last physical examination: _____ Name of provider who performed your last exam _____

Address of Physician _____

City, State _____

24. **Have you ever had any of the following? If so, give approximate date:**

	Yes	No	Give Date		Yes	No	Give Date
Chest X-Ray	☐	☐	_____	Pulmonary Function Studies	☐	☐	_____
Back (Spine) X-Ray	☐	☐	_____	EKG	☐	☐	_____
Audiogram	☐	☐	_____	Exercise (Stress) EKG	☐	☐	_____

25. **Physician Remarks:** _____

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT LEAVING OUT OR MISREPRESENTING FACTS CALLED FOR ABOVE MAY BE CAUSE FOR REFUSAL OF EMPLOYMENT OR SEPARATION FROM THE COMPANY. I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE COMPANY MEDICAL EXAMINER WITH A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY PHYSICAL EXAM.

Date _____ **Signature** _____

UHMS PHYSICAL EXAMINATION FORM

Employer	Date	Date of Birth	Age

1. Last Name	First Name	Middle Name	2. SSN

3. Height (inches)	4. Weight (pounds)	5. Body Fat (%) (Optional)	6. BMI (Optional)

7. Temperature	8. Blood Pressure	9. Pulse/Rhythm	10. General Appearance/Hygiene	11. Build
	/			

12. Distant Vision:	13. Near Vision: Jaeger	Near Vision Corrected	14. Color Vision (Test Performed and Results)
R. 20/_____Corr. to 20/_____	R. 20/_____	R. 20/_____	
L. 20/_____Corr. to 20/_____	L. 20/_____	L. 20/_____	

15. Field of Vision (Degrees) R ° L ° **16. Contact Lenses** Yes ☐ No ☐

NORMAL	ABNORMAL	Check each item in appropriate column (enter NE for Not Evaluated)	REMARKS
		17. Head, Face, Scalp	
		18. Neck	
		19. Eyes	
		20. Ears – General (internal and external canal)	
		21. Eustachian Tube Function	
		22. Tympanic Membrane	
		23. Nose (Septal Alignment)	
		24. Sinuses	
		25. Mouth and Throat	
		26. Chest	
		27. Lungs	
		28. Heart (Thrust, Size, Rhythm, Sounds)	
		29. Pulses (Equality, etc.)	
		30. Vascular System (Varicosities, etc.)	
		31. Abdomen and Viscera	
		32. Hernia (All Types)	
		33. Endocrine System	
		34. G-U System	
		35. Upper Extremities (Strength, ROM)	
		36. Lower Extremities (Except Feet)	
		37. Feet	
		38. Spine	
		39. Skin, Lymphatics	
		40. Anus and Rectum	
		41. Sphincter Tone	

NEUROLOGICAL EXAMINATION

42. CRANIAL NERVES

		NORMAL	ABNORMAL	NE
I	Olfactory			
II	Optic			
III	Oculomotor			
IV	Trochlear			
V	Trigeminal			
VI	Abducens			

		NORMAL	ABNORMAL	NE
VII	Facial			
VIII	Auditory			
IX	Glossophayrngeal			
X	Vagus			
XI	Spinal Accessory			
XII	Hypoglossal			

43. REFLEXES

DEEP TENDON

	Left					Right				
	0	1	2	3	4	0	1	2	3	4
Triceps										
Biceps										
Patella										
Achilles										

PATHOLOGICAL

	Left		Right	
	Present	Absent	Present	Absent
Babinski				
Hoffman				
Ankle Clonus				

SUPERFICIAL

	Present	Absent	NE
Upper Abdomen			
Lower Abdomen			
Cremasteric			

44. CEREBELLAR FUNCTION

	0	1	2	3	4
Ataxia					
Tremor (intention)					

	Normal	Abnormal
Finger to Nose		
Heel to Shin (Sliding)		

45. MUSCLE STRENGTH

	1	2	3	4	5
Right Upper Extremity					
Left Upper Extremity					
Right Lower Extremity					
Left Lower Extremity					

TONE

Normal	Abnormal

46. PROPRIOCEPTION

	Left		Right	
	Normal	Abnormal	Normal	Abnormal
Joint Position Sense				
Stereognosis				
Vibratory Sensation				

47. NYSTAGMUS

	Present	Absent
End Point Lateral Gaze		
Pathological		

48. SENSATION

	Normal	Abnormal
Hot		
Cold		

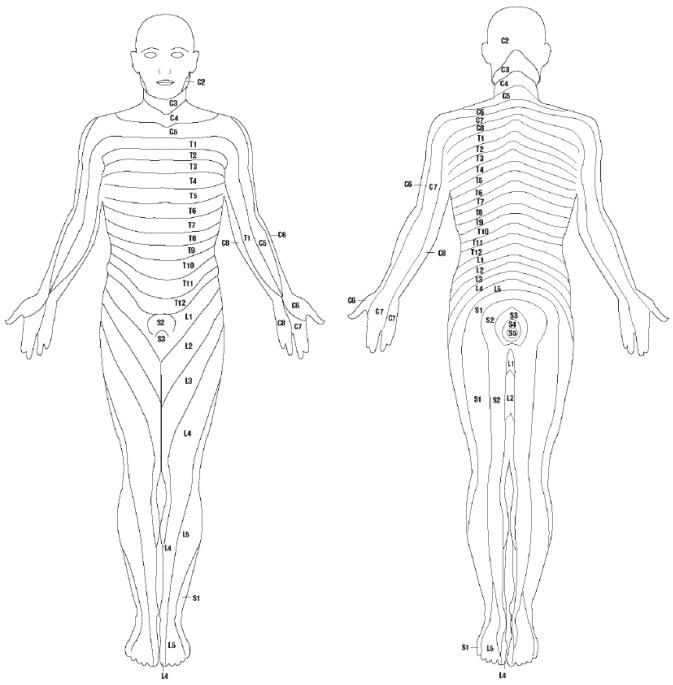
	Normal	Abnormal
Soft		
Sharp		

Two Point Discrimination	
Normal	
Abnormal	

49. ROMBERG

Absent	
Present	

50. MISCELLANEOUS REMARKS



LABORATORY FINDINGS

51. Urinalysis

Color _____
Appearance _____
Specific Gravity _____
pH _____

	0	1+	2+	3+	4+
Sugar					
Blood					
Ketones					
Bilirubin					
Protein					

52. Blood Tests (attach reports) Notes

CBC ☐ Normal ☐ Abnormal _____
Sickle Cell ☐ Positive ☐ Negative _____
CMP ☐ Normal ☐ Abnormal _____

53. Pulmonary Function

FVC _____
FEV1 _____
FEV1/FVC _____

54. X-rays

Chest ☐ Normal ☐ Abnormal
Lumbar Spine ☐ Normal ☐ Abnormal

55. Electrocardiogram

Static _____
Exercise Stress _____

56. Audiogram

Hz	500	1000	2000	3000	4000	6000	8000
Left							
Right							

57. Drug Screen

☐ Not collected
☐ Collected, results sent to employer

Work Status

☐ Fit for work as an inside attendant
☐ Cleared with restrictions _____
☐ Further evaluation needed _____
☐ Unfit _____
Comments:

Examiner Signature _____
Examiner Name _____
Address _____
_____
Phone Number _____

Date of Examination _____