Medical History Questionnaire

This form is voluntary. You may ignore it, complete parts of it, or fill it out fully. It is intended solely for your self-protection at sea, by making your medical history available for reference at Medical Advisory Systems/ MedAire, 80 E. Salado Parkway, Suite 610, Tempe, AZ 85281. Medical Advisory Systems/ MedAire is the consulting medical service ashore that will be contacted should you have an injury or illness which the limited facilities of the ship are unable to treat satisfactorily.

Newcomers to seagoing should realize that despite constant attention to safety the ocean presents risks not found on land. Ships of the SIO fleet operate far from ports, rarely carry a doctor or any individual with advanced medical expertise, and have very limited medical facilities and supplies. Filing your medical history on this form is one way to enhance your personal safety; the information will be available at Medical Advisory Systems/ MedAire even if you are unconscious or unable to talk over the radio. For further protection you might want to give a copy to the captain. Then your information is available on the ship even if radio communication breaks down.

Please return forms to:
MedAire Corporate Headquarters
80 East Rio Salado Pkwy, Suite 610
Tempe, AZ 85281
Phone: +1.480.333.3700
Fax: +1.480.333.3592
info@medaire.com

Attn: Manolo

For further information or questions, office contacts are: 858-534-2840 (phone); 858-822-5811 (fax);
shipsked@ucsd.edu

The form should be sent directly to Medical Advisory Systems/ MedAire. Due to privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) no copy will be forwarded to or reviewed at SIO. If you wish to bring a copy aboard in your personal possession that is your choice.

We hope this form is never needed. We urge you to file it just in case.
Medical History Questionnaire

General Information

Name
Address
Telephone Number
Social Security Number
Emergency Contact
Address
Telephone Number
Date of Birth
Place of Birth
Race/Nationality
Native Language
Educational Level
Marital Status
Citizenship

Family Illness
Check if there is any history in your family of:

- Diabetes
- Easy Bleeding
- Obesity
- Allergy
- High Blood Pressure
- Jaundice
- Gout
- High Blood Fats
- Stroke
- Alcoholism
- Asthma
- Cancer of _____________
- Heart Trouble
- Tuberculosis
- Psychiatric Illness
- Other _______________

Please explain:

Statement of Present Health

Your statement of present health: □ Excellent □ Good □ Fair/Poor (explain)

Please explain:

Do you take non-prescription drugs routinely? □ No □ Yes (specify)

Please specify: 

Do you take prescription drugs routinely? □ No □ Yes (specify)

Please specify: 

Do you take recreational drugs? □ No □ Yes (specify)

Please specify: 

Are you under the care of a physician now? □ No □ Yes (specify)

Please specify: 

What is your:

Height _______ Weight _______ Usual blood pressure _________ Usual pulse _________ Color hair/eyes ____________
**Medical History Questionnaire**

Vision:

<table>
<thead>
<tr>
<th>Eye</th>
<th>With glasses</th>
<th>Without glasses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
<td>/20</td>
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<td>Left</td>
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</table>

**Past Medical History** (for additional space use back page)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>NS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scarlet fever</td>
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<td>Rheumatic fever</td>
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<td>Swollen or painful joints</td>
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<tr>
<td>Frequent or severe headache</td>
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<td>Dizziness/fainting spells</td>
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<td>Eye trouble</td>
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<tr>
<td>Ear, nose or throat trouble</td>
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<tr>
<td>Hearing loss</td>
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<td>Chronic or frequent colds</td>
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<td>Severe tooth/gum trouble</td>
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<td>Sinusitis</td>
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<td>Hay fever</td>
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<tr>
<td>Head injury</td>
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<tr>
<td>Skin diseases</td>
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</tbody>
</table>

Have you ever been refused employment, unable to hold a job or stay in school because of:

- Sensitivity to chemicals, dust, sunlight, etc.
- Inability to perform certain motions.
- Inability to assume certain positions.
- Other medical reasons (If yes, give reasons).

Have you ever been treated for a nervous condition? (If yes, specify when, where and give details)

Have you ever been denied life insurance? (If yes, state reason and give details)

Have you had, or have you been advised to have any operations (If yes, describe and give age)

Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, name of doctor and complete address of hospital)

Date of last physical: Date of last hospitalization: No. of days:

Have you consulted or been treated by clinics, physicians, healers or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital and details)

Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reasons for rejection)

Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reasons and type of discharge: honorable, other than honorable, unfit or unsuitable)

Have you ever received, is there pending, or have you applied for pension for compensation for existing Disability? (If yes, specify what kind, granted by whom, what amount, when and why)

Weight at age 18:

Have you ever:

- Lived with anyone who had tuberculosis?
- Coughed up blood?
- Bled excessively after injury or tooth extraction?
- Attempted suicide?
- Been a sleepwalker?

Do you:

- Wear glasses or contact lenses?
- Have vision in both eyes?
- Wear a hearing aid?
- Stutter or stammer habitually?
- Wear a brace, back support or truss?
### Medical History Questionnaire

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>NS*</th>
<th>Yes</th>
<th>No</th>
<th>NS*</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Thyroid trouble</td>
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<td>Adverse reaction to serum, Drug, medicine or foods</td>
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<td>STD – syphilis, gonorrhea</td>
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<td>Glaucoma</td>
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<td>Frequent indigestion, stomach ulcer</td>
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<td>Stomach, liver or intestinal trouble</td>
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<td>Adverse reaction to serum, Drug, medicine or foods</td>
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<td>Arthritis, rheumatism, or bursitis</td>
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<td>Glaucoma</td>
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<td>Pain or pressure in chest</td>
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<td>Bone, joint or other deformity</td>
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<td>Chronic cough</td>
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<td>Lameness</td>
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<td>Use tobacco</td>
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<td>Palpitation/pounding heart</td>
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<td>Loss of finger or toe</td>
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<td>Use alcohol</td>
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<td>Heart Trouble</td>
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<td>Kidney/bladder trouble</td>
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<td>Recurrent back pain</td>
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<td>High or low blood pressure</td>
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<td>Herpes</td>
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<td>Painful or “trick” shoulder or Elbow</td>
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<td>Bronchitis</td>
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<td>Females only: Have you ever</td>
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<td>Been treated for a female</td>
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<td>Disorder</td>
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<td>Had a change in menstrual</td>
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**NS* - Not Sure**

### Immunizations

**Have you had any of the following immunizations? Date/Mo/Yr (example: 30 Nov 03)**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Yes</th>
<th>No</th>
<th>NS*</th>
<th>Date</th>
<th>Yes</th>
<th>No</th>
<th>NS*</th>
<th>Date</th>
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<tbody>
<tr>
<td>Tetanus</td>
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<td>BCG (TB)</td>
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<td>Gamma Globulin</td>
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<td>Smallpox</td>
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<td>Cholera</td>
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<td>Diphtheria</td>
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<td>Yellow Fever</td>
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<td>Typhoid</td>
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<td>Malaria</td>
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<td>Plague</td>
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<td>Typhus</td>
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<td>Other</td>
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</table>

**NS* - Not Sure**

### Other

Please provide any relevant details or additional conditions:

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

A. Standard Medical Advisory Systems, Inc. (Medical Advisory Systems/ MedAire) Medical Release

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 hereby authorize facilities holding my medical records to release a transcript to the physicians and Medical Advisory Systems, Incorporated (Medical Advisory Systems/ MedAire) for the purpose of providing medical advice for my treatment for medical problems which could occur aboard a unit of the company subscribing to the service of Medical Advisory Systems/ MedAire. I also authorize Medical Advisory Systems/ MedAire to maintain, periodically update and release this information to shoreside medical facilities for continuation of medical care.

B. HIPAA Form for Consent for Release of Medical Information

(Note: This Consent form is for release by Medical Advisory Systems/ MedAire through use or disclosure of protected patient health information for purposes of payment, treatment and health care operations. You, as the patient, should note the following regarding the release of this information:

1. You must sign this Consent for Release of Medical Information prior to use or disclosure of your protected health information by Medical Advisory Systems/ MedAire;
2. you may refer to Medical Advisory Systems/ MedAire’s Notice of Privacy Practices for a more complete description of uses and disclosures permitted by law;
3. you have the right to review Medical Advisory Systems/ MedAire’s Notice of Privacy Practices prior to signing this Consent for Release of Medical Information Form;
4. Medical Advisory Systems/ MedAire has reserved the right to change the Notice of Privacy Practices;
5. you have the right to request Medical Advisory Systems/ MedAire to restrict how your protected health information is used or disclosed to carry out treatment, payment or health care operations;
6. Medical Advisory Systems/ MedAire may, but is not required to agree to any of the restrictions you might have requested;
7. if Medical Advisory Systems/ MedAire agrees to a requested restriction, the restriction is binding on Medical Advisory Systems/ MedAire;
8. you have the right to revoke your consent in writing, except to the extent that Medical Advisory Systems/ MedAire has already acted on the consent.)

Consent Date: __________________________ Purge Date: __________________________
(Six years from Consent Date)

To: (Clinic Name):
Address: ________________________________________________________________
______________________________________________________________
Telephone: ___________________________ FAX Number: __________________________

From: (Employee-please print):
Name:  ________________________________________________________________

Identifying info: Date of Birth: __________________________ SSN: __________________________
Address: ________________________________________________________________
Medical History Questionnaire

Phone: ____________________________________________
Employer: __________________________________________

This is to consent to the release of the following of my medical records to my employer and/or its medical agent, Medical Advisory Systems, Incorporated:

<table>
<thead>
<tr>
<th>Description of Record</th>
<th>Person Making Request</th>
<th>Authorization Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

I also authorize Medical Advisory Systems/ MedAire to release the above-described medical information to other medical facilities or medical practitioners for use in my medical treatment or physical evaluation. This consent only applies to the employer named above and Medical Advisory Systems/ MedAire. As the “patient” herein, I also have read and understand the eight (8) statements set out above.

C. HIPAA Form for Authorization for Release of Medical Information

(Note: This Authorization form is in addition to the Consent for Release of Medical Information and is for release of patient information for purposes other than payment, treatment and health care operations. An example of a need for this form is disclosure to an employer for a pre-employment physical.)

Printed Name/Organization Identifying Entity Making This Authorization Request: ________________________________

Authorization Date: ___________  Purge Date: ___________ (Six years from Authorization Date)

To: (Clinic Name): ______________________________________________________
Address: __________________________________________________________________

From: (Employee-please print):
Name: _____________________________________________________________________
Identifying info: Date of Birth: ________________
SSN: __________________________
Address: __________________________________________________________________
Phone: ____________________________________________________________________
Employer: __________________________________________________________________

This is to authorize the release of the following of my medical records to my employer and/or its medical agent, Medical Advisory Systems, Incorporated:

<table>
<thead>
<tr>
<th>Description of Record</th>
<th>Person Making Request</th>
<th>Authorization Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
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This authorization only applies to the employer named above and Medical Advisory Systems/ MedAire. I also understand that: I have a right to revoke this authorization in writing; that the information described above may be subject to re-disclosure; and if this authorization is signed by a representative, a description of the representative’s authority must be given. (E.g., a certified copy of a power of attorney must be attached to this form.)

_______________________________ (Witness to employee signature)

Medical Advisory Systems/ MedAire, 80 E. Salado Parkway, Suite 610, Tempe, AZ  85281
Medical History Questionnaire

Document Number: