PRE-EMPLOYMENT MEDICAL EXAMINATION AND HISTORY REPORT

APPLICANTS AND EXAMINING FACILITIES: Please DO NOT write in "AGENCY USE ONLY" areas.

APPLICANTS: Complete all portions of this form before reporting for the medical examination. **Failure to answer any questions or disclose a known medical condition or failure to place signature where indicated may result in disqualification from employment consideration.** Please print or type. Each "yes" answer to a medical history question requires that you provide a brief explanation in the comment section provided. (NOTE: Because this exam may include a fitness test, please dress appropriately.) This examination is being conducted for employment purposes only; it does not substitute for a periodic health examination conducted by your private provider.

ATTENTION VETERANS: The Questionnaire for National Security Positions (SF-86) does not require you to disclose mental health counseling on that form if such counseling was "strictly related to adjustments from service in a military combat environment" (SF-86, Section 21 Mental and Emotional Health). **However, all mental health counseling or treatment must be disclosed on this Medical Examination and History Report form in order to determine if you meet the medical qualifications for the position.**

APPLICANT'S NAME (Last, First, Middle Initial)		SOCIAL SECURITY NUMBER:
VETERANS' PREFERENCE ELIGIBILITY: ☐ Yes ☐ No	SEX: ☐ Male ☐ Female	DATE OF BIRTH: (mm/dd/yy)
YOUR CURRENT OCCUPATION:	YOUR CURRENT EMPLOYER:	
HOW LONG IN CURRENT POSITION? (years/months)		

CHECK THE OCCUPATION FOR WHICH YOU ARE BEING CONSIDERED: ☐ FPS ☐ ICE

- ☐ Criminal Investigator (GS-1811)
- ☐ Deportation Officer (GS-1801)
- ☐ Police Officer (GS-0083)
- ☐ Physical Security Specialist (GS-0800)
- ☐ Law Enforcement Training Specialist (GS-1701)
- ☐ Other: _____

EXAMINING FACILITIES: **(Do NOT bill examinee for exam. CHS is responsible for all payments.)** Conduct medical exam and all other required services in accordance with instructions provided by the contracting organization. Complete this form except where indicated. Please print or type.

NAME AND ADDRESS OF EXAMINING FACILITY:	DATE OF EXAMINATION:
	NAME OF EXAMINING PHYSICIAN:
	PHONE NUMBER: (including area code)

REQUIRED SERVICES: (check when completed and attach reports)

- ☐ Medical History
- ☐ General Physical Examination (including waist measurements and fitness questionnaire)
- ☐ Audiometry
- ☐ Repeat Audiometry, if appropriate
- ☐ Vision Screening
- ☐ EKG with interpretation
- ☐ TB Test
- ☐ 1View Chest Xray, if appropriate per TB form page 12

AGENCY USE ONLY

APPLICANT'S NAME:	SSN:	DATE:

MEDICAL HISTORY

Check "yes" or "no" for **each** item. For each "yes," you must provide an explanation in the space below. **Explanations to "yes" answers must include Date, Where, How and any Follow-up Testing/Treatment.**

1 Have you ever been refused employment or been unable to hold a job or stay in school due to any medical condition? (If yes, specify date, where and give details.) ☐ Yes ☐ No

2 Have you ever been treated for a mental health condition? (If yes, specify date, where, and give details.) ☐ Yes ☐ No

3 Have you had, or have you ever been advised to have, any surgical operation? (If yes, describe and give date, details of problem and name of procedure.) ☐ Yes ☐ No

4 Have you ever been a patient in any type of hospital? (If yes, specify date, where, why.) ☐ Yes ☐ No

5 Have you ever consulted or been treated by clinics, physicians, healers, or other practitioners other than for minor illness? (If yes, give date and complete details.) ☐ Yes ☐ No

6 Have you ever been rejected for or separated from military service because of physical, mental, or other medical reasons? (If yes, give date, reason, and type of discharge, whether honorable or other than honorable, for unfitness or unsuitability.) ☐ Yes ☐ No

7 Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why and attach most recent disability rating decision.) ☐ Yes ☐ No

8 Are you: ☐ Left handed OR ☐ Right handed

9 Year of last Tetanus booster:_____ ☐ I don't know the year of my last Tetanus booster

10 MEDICATIONS: (List prescription and non-prescription medications, dosage,and reason for taking. Include supplements or herbals.) ☐ No Meds

Medication	Dosage/frequency	Reason	Currently Taking	Taken in the last year
			☐	☐
			☐	☐
			☐	☐

ALLERGIES/REACTIONS: (List substances to which you are allergic or to which you have reactions and any medications taken for their treatment.) ☐ No Allergies

APPLICANT'S NAME:	SSN:	DATE:

MEDICAL HISTORY

GENERAL

Have you ever experienced any of the following? (Explain "yes" responses in the space below or at the bottom of the page.)

12 Diabetes	☐ Yes	☐ No	Treatment:__diet __pills __insulin
13 Thyroid disease	☐ Yes	☐ No	
14 Pituitary gland problem	☐ Yes	☐ No	
15 Blood disorder	☐ Yes	☐ No	
16 Anemia	☐ Yes	☐ No	
17 Back pain or injury	☐ Yes	☐ No	
18 Back surgery	☐ Yes	☐ No	
19 Joint pain, swelling, or injury	☐ Yes	☐ No	
20 Trouble using hip/knee/shoulder	☐ Yes	☐ No	
21 Trouble walking	☐ Yes	☐ No	
22 Loss of joint/limb movement	☐ Yes	☐ No	
23 Loss of strength or muscle weakness	☐ Yes	☐ No	
24 Limb or finger amputation/loss	☐ Yes	☐ No	
25 Arthritis	☐ Yes	☐ No	
26 Gout	☐ Yes	☐ No	
27 Skin problems or Urticaria	☐ Yes	☐ No	
28 Urinary pain/infection/bleeding	☐ Yes	☐ No	
29 Kidney disease or kidney stones	☐ Yes	☐ No	Date of last episode: / /
30 Headaches or migraines	☐ Yes	☐ No	
If yes, how often?_____			
Able to work during headache?	☐ Yes	☐ No	
31 Localized weakness or numbness	☐ Yes	☐ No	
32 Tingling in head/hands/legs	☐ Yes	☐ No	
33 Lack of coordination	☐ Yes	☐ No	
34 Epilepsy (seizures)	☐ Yes	☐ No	Date of last episode: / /
35 Tremors/shakiness	☐ Yes	☐ No	
36 Fainting/syncope (blacking out)	☐ Yes	☐ No	
37 Loss of sensation	☐ Yes	☐ No	
38 Persistent stomach/abdominal pain	☐ Yes	☐ No	
39 Stomach ulcers	☐ Yes	☐ No	
40 Vomiting blood	☐ Yes	☐ No	
41 Persistent diarrhea/constipation	☐ Yes	☐ No	
42 Blood in stool	☐ Yes	☐ No	
43 Liver disease	☐ Yes	☐ No	
44 Hepatitis	☐ Yes	☐ No	Type: ☐ A ☐ B ☐ C
45 Received the Hepatitis B vaccine	☐ Yes	☐ No	#Shots: ☐ 1 ☐ 2 ☐ 3
46 Gall bladder problems	☐ Yes	☐ No	
47 Hernia	☐ Yes	☐ No	If yes, year repaired:
48 Psychiatric/psychological evaluation or treatment	☐ Yes	☐ No	
49 Episodes of depression	☐ Yes	☐ No	
50 Periods of nervousness	☐ Yes	☐ No	
51 Sleep disorders or sleep apnea	☐ Yes	☐ No	
52 Treatment for alcoholism or addiction	☐ Yes	☐ No	
53 Are you pregnant?	☐ Yes	☐ No	
54 Suicide attempts or plans	☐ Yes	☐ No	
55 Organ transplant (e.g.kidney, etc)	☐ Yes	☐ No	
56 Heat stroke	☐ Yes	☐ No	
57 Frost bite	☐ Yes	☐ No	

APPLICANT'S COMMENTS (For all "yes" answers above, you must include date, where (body part affected), how and any follow-up testing and/or treatments.)

Question Number	Date of Onset	Details

Note to Examining Physician: All "yes" responses require detailed comments by applicant and examining physician. Examining physician comments should be recorded on page 7.

APPLICANT'S NAME:	SSN:	DATE:

MEDICAL HISTORY

VISION

THIS PORTION OF THE MEDICAL HISTORY IS REPEATED ON THE VISION EXAM FORM.
PLEASE ANSWER ALL QUESTIONS ON **BOTH** FORMS.

Have you had or are you currently experiencing any of the following: (Explain "yes" in space below)

58 Blurred vision ☐ Yes ☐ No
59 Color blindness ☐ Yes ☐ No
60 Trouble seeing at night ☐ Yes ☐ No
61 Glaucoma ☐ Yes ☐ No
62 Cataracts ☐ Yes ☐ No
63 Eye disease ☐ Yes ☐ No
64 Do you wear glasses? ☐ Yes ☐ No
65 Do you wear contact lenses? ☐ Yes ☐ No
66 Have you ever had eye surgery (e.g., RK, PRK, LASIK, cataracts)? ☐ Yes ☐ No
(If yes specify surgery and date)

VISION EXAMINATION IS PERFORMED AT THE VISION CENTER INDICATED IN YOUR INSTRUCTIONS.

AUDIO

Have you experienced any of the following? (Answer each question; explain "yes" response in the space below.)

67 Difficulty hearing ☐ Yes ☐ No
68 Ringing in ears (tinnitus) ☐ Yes ☐ No
69 Dizziness or balance problem ☐ Yes ☐ No
70 Chronic ear pain/infection ☐ Yes ☐ No
71 Eardrum perforation ☐ Yes ☐ No
72 Ear surgery ☐ Yes ☐ No
73 Loud, constant noise or music within the past 15 hours ☐ Yes ☐ No
74 Loud, sudden noise in past 15 hours ☐ Yes ☐ No
75 Are you in a hearing conservation program? ☐ Yes ☐ No
76 Do you use hearing protective equipment? ☐ Yes ☐ No
77 Do you wear a hearing aid? ☐ Yes ☐ No
If yes, specify ☐ right ☐ left ☐ both

CARDIO-PULMONARY

78 Chest Pains ☐ Yes ☐ No
79 Swelling of ankles or feet ☐ Yes ☐ No
80 Leg pains ☐ Yes ☐ No
81 Mitral valve prolapse ☐ Yes ☐ No
82 Heart murmur ☐ Yes ☐ No
83 History or diagnosis of heart disease ☐ Yes ☐ No
84 Coronary bypass surgery/other heart surgery ☐ Yes ☐ No
85 Heart palpitations (rapid or skipped heart beat) ☐ Yes ☐ No
86 Heart attack or stroke ☐ Yes ☐ No
87 Abnormal electrocardiogram (EKG) ☐ Yes ☐ No
88 Abnormal stress test (treadmill) ☐ Yes ☐ No
89 History of high blood pressure ☐ Yes ☐ No

90 Cold hands or feet when others
91 are comfortable in the same room ☐ Yes ☐ No
92 Numbness of hands or feet ☐ Yes ☐ No
93 Phlebitis or blood clots ☐ Yes ☐ No
94 Problems with breathing,
95 wheezing, or persistent cough ☐ Yes ☐ No
90 History of bronchitis ☐ Yes ☐ No
91 History of asthma ☐ Yes ☐ No
If yes, answer a, b, and c below:
a. Date of last ER visit or hospitalization:_____
b. How often is inhaler used? ____ times yearly
c. Inhaler use before certain activities? ☐ Yes ☐ No
96 Shortness of breath ☐ Yes ☐ No
97 Exposure to tuberculosis ☐ Yes ☐ No
98 Previous positive TB skin test ☐ Yes ☐ No

APPLICANT'S COMMENTS (For all "yes" answers above, you must include date and any follow-up testing and/or treatments).

Question Number	Date of Onset	Details

Note to Examining Physician: All "yes" responses require detailed comments by applicant and examining physician. Examining physician comments should be recorded on page 7.

APPLICANT'S NAME:	SSN:	DATE:

MEDICAL HISTORY

99 Have you ever had or are you currently being treated for any illness or injury other than those noted on pages 2 - 4?) (If yes, specify date, where, and give details.) ☐ Yes ☐ No

OTHER MEDICAL CONSIDERATIONS

100 Have you ever smoked? ☐ Yes ☐ No

If yes, when? ☐ current ☐ past -- number of years since quitting _____

Type: ☐ cigarettes ☐ pipe ☐ cigar

Number per day: _____

For how many years: _____

101 What is your average alcohol consumption in a week? _____ drinks per week

(1 drink = 12 oz. Beer, 1 glass Wine, 1.5 oz. Liquor)

102 When do you drink alcohol? ☐ Weekdays ☐ Weekends ☐ Both ☐ I don't drink alcohol.

I certify that all of the information I have provided on this form is complete and accurate to the best of my knowledge, and that submitting information that is incomplete, misleading, or untruthful may result in termination, criminal sanctions, or delays in processing this form for employment. Furthermore, consistent with the Privacy Act Statement, I authorize the release to my employing agency of all information contained on this examination form and all other forms generated as a direct result of my examination.

Applicant MUST Sign

below in the presence of a witness from the examining facility.

APPLICANT'S SIGNATURE: DATE:

WITNESS' SIGNATURE: DATE:

APPLICANT'S NAME:	SSN:	DATE:

FITNESS QUESTIONNAIRE

BEFORE answering the following, please read the Practical Exercise Performance Requirements (PEPR) you received from the Dallas Service Center which was included in the Employment Information booklet. If there are **ANY** physical tasks or training exercises on the PEPRs that you currently **CANNOT** perform, list them below.

Are you familiar with the physical requirements of the position for which you applied?

☐ Yes ☐ No

Over the last six weeks, on average:

How many times per week have you been running? _____ times per week

What distance do you run each time? _____ miles (use fractions, if appropriate)

How many minutes do you usually run without stopping? _____ minutes

Describe your current physical activity or exercise program:

Intensity: ☐ Low ☐ Moderate ☐ High

Frequency: _____ Days per week

Duration: _____ Minutes per session

Types of Activities:

Are you capable of performing the following:

Vigorous aerobic activity at least 3 hrs/week…… ☐ Yes ☐ No

1 1/2 mile timed run…… ☐ Yes ☐ No

1/4 mile run…….. ☐ Yes ☐ No

Quickly get in/out of mid-sized car with ease…… ☐ Yes ☐ No

Squat or kneel for up to 45 seconds repeatedly…… ☐ Yes ☐ No

Kneel for 2-3 minutes at a time repeatedly…… ☐ Yes ☐ No

Do you have any lifting restrictions (If yes, answer next question)…… ☐ Yes ☐ No

What is the maximum number of pounds you are allowed to lift? _____ lbs

Place a check next to the response that best describes how often you lift and/or carry objects for each weight category:

Weight (lbs)	**Never or Rarely** (less than 2/yr)	**Occasionally** (Once every 2 months)	**Frequently** (1/week or more)
10-25 lbs	___ Never or rarely	___ Occasionally	___ Frequently
26-49 lbs	___ Never or rarely	___ Occasionally	___ Frequently
50-69 lbs	___ Never or rarely	___ Occasionally	___ Frequently
70 lbs	___ Never or rarely	___ Occasionally	___ Frequently

How often do you participate in each of the following acivities?

Activity	**Never or Rarely** (less than 2/yr)	**Occasionally** (Once every 2 months)	**Frequently** (1/week or more)
Climb Stairs			
(13-16 steps)	___ Never or rarely	___ Occasionally	___ Frequently
Stoop/Bend	___ Never or rarely	___ Occasionally	___ Frequently
Kneel	___ Never or rarely	___ Occasionally	___ Frequently

Applicant's Comments: If you do not know your capabilities, discuss below:

APPLICANT'S NAME:	SSN:	DATE:

EXAMINING PHYSICIAN'S COMMENTS

GENERAL INSTRUCTIONS:

All "yes" responses in the Medical History **require detailed comments** by the examining physician. Examinations are not complete without this detailed information. Please comment in the space provided below. If more space is needed, supply progress notes.

For all applicable conditions, the examining physician must comment on the following:

1 Name, date, and result of surgeries or medical tests performed, as well as emergency or urgent care during the past year.

2 Medications used and relief provided.

3 Whether or not the applicant is experiencing any current or recent problems as a result of the medical condition and whether there are any limitations. If yes, describe in detail. If not, state activities the applicant can perform which demonstrate capabilities.

4 For **diabetics**, number of hypoglycemic episodes during the past year, chronic or significant complications which may pose a hazard to the applicant or others, degree of diabetic control, and basis for this conclusion.

5 **Include with examination results any relevant documents shown to you by the applicant, such as military disability evaluations or medical reports.**

EXAMPLES:

1 Applicant writes "knee surgery, 1988" in response to Question #3.

Examining Physician's Comment:
Acceptable: "#3 - ACL repair knee for pain and swelling from a football injury. Now notes mild discomfort in knee in rainy weather; otherwise, able to race-walk 25 miles per week and has no limitations."
Not Acceptable: "OK now" or "WNL."

2 Applicant checks "yes" in response to Question #30 about migraine headaches.

Examining Physician's Comments:
Acceptable: "#30 - Mild headache approximately every three months for the past 10 years. Never had a medical evaluation for this. Uses OTC NSAIDs with relief."

Not Acceptable: "Occasional migraine."

ITEM #	DETAILED COMMENTS:

MD OR DO MUST sign in indicated spaces. No PA, NP, LPN, RN, or other signatures accepted -- MD OR DO ONLY

Typed or Printed Name of Examining Physician:	Reviewed and discussed medical history with the applicant: ☐ Yes ☐ No	SIGNATURE OF EXAMINING PHYSICIAN:	DATE:

APPLICANT'S NAME:	SSN:	DATE:

EXAMINING PHYSICIAN

BODY MEASUREMENTS

Height:_____inches (without shoes) Weight:_____ pounds

Measure AGAINST THE SKIN while examinee is STANDING
(measure circumference and specify in inches)

Waist _____

VITAL SIGNS

	Initial Reading	Repeat (for pulse > 100)
Pulse:		

	Initial Reading	Repeat (for BP > 140/90)
Blood pressure (sitting):		

Physician's Comments:

AUDIOLOGY (Indicate best results and attach all reports.)

If an audio exceeds 30 @ 500-2000 OR 40 @ 3000, repeat 15 hrs. after quiet time.

Was repeat Audio required/performed? ☐ Yes ☐ No Tested with Hearing Aid? ☐ Yes ☐ No
(If yes, attach ALL reports, clearly indicating **Initial vs. Repeat**. Indicate BEST results on the grid below:

Daily Calibration Method: ☐ Oscar (machine) ☐ Biological (person) **Yearly** Calibration Date:

Frequency:	500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz	8000 Hz
Right Ear							
Left Ear							

Right Ear Normal	Right Ear Abnormal		Left Ear Normal	Left Ear Abnormal
☐	☐	Canal/External Ear	☐	☐
☐	☐	Tympanic Membrane	☐	☐

Physician's Comments:

Physician's Comments (explain abnormalities or contraindications in space below):

APPLICANT'S NAME:	SSN:	DATE:

EXAMINING PHYSICIAN

HEAD AND NECK

	Normal	Abnormal		Normal	Abnormal
Head, face, neck (thyroid)	☐	☐	Ocular motility	☐	☐
Nose/sinuses	☐	☐	Ophthalmoscopic findings	☐	☐
Mouth/throat	☐	☐	Speech	☐	☐
Pupils equal/reactive	☐	☐			

Physician's Comments (explain abnormalities or contraindications in space below):

☐ NA

CARDIO/PULMONARY

	Normal	Abnormal
Lungs/chest	☐	☐
Heart (murmur, irregular beats)	☐	☐
Vascular (varicosities)	☐	☐
EKG (Attach EKG with interpretation.)	☐	☐
Chest X-ray (Refer to TB Screening Form for x-ray requirements)	☐	☐

Chest X-ray **Not Performed** at this time; indicate by checking box: ☐

Physician's Comments (explain abnormalities or contraindications in space below):

☐ NA

MUSCULOSKELETAL FINDINGS

	Normal	Abnormal
Upper extremities (strength)	☐	☐
Upper extremitites (range of motion)	☐	☐
Lower extremities (strength)	☐	☐
Lower extremities (range of motion)	☐	☐
Feet/Toes	☐	☐
Hands/Fingers	☐	☐
Spine	☐	☐
Flexibility	☐	☐
Deep tendon reflexes	☐	☐
Other neurological	☐	☐

Physician's Comments (explain abnormalities or contraindications in space below):

☐ NA

OTHER MEDICAL SYSTEMS

	Deferred	Normal	Abnormal
Genito-urinary system	☐	☐	☐
Abdomen, viscera		☐	☐
Lymphatic		☐	☐
Skin (scars/unique markings)		☐	☐
Mental/emotional affect (describe, if abnormal)		☐	☐
Other: (describe, if abnormal)		☐	☐

Physician's Comments (explain abnormalities or contraindications in space below):

☐ NA

APPLICANT'S NAME:	SSN:	DATE:

EXAMINING PHYSICIAN

PHYSICIAN'S SUMMARY OF SIGNIFICANT MEDICAL FINDINGS AND RECOMMENDATIONS

(Please do not include any conclusions regarding fitness for duty. This service will be provided by the Agency Medical Review Officer.)

☐ NA

MD OR DO MUST sign in indicated spaces. No PA, NP, LPN, RN, or other signatures accepted -- MD OR DO ONLY

NAME OF EXAMINING PHYSICIAN: (Please print or type.)

PHYSICIAN'S SIGNATURE: **DATE:**

APPLICANT'S NAME:	SSN:	DATE:

VISION TEST

Have you ever had or are you currently experiencing any of the following:

	Yes	No
Blurred vision?.....	☐	☐
Trouble seeing at night?…..……	☐	☐
Diagnosis of night vision deficiency?	☐	☐
Color blind?.....	☐	☐
Cataracts?.....	☐	☐
Glaucoma?……..	☐	☐
Diagnosis of any eye disease?.....	☐	☐
Have you had any type of eye surgery (i.e. Radial Keratotomy, LASIK, PRK, cataracts, etc.)?.....	☐	☐

If yes, please explain what specific surgery was performed and the date of the surgery

If 'yes', give name of surgery: _____

Date of surgery: _____

Each "yes" response requires comment below:

Check all boxes below that apply to you:

☐ I do not wear corrective lenses

☐ I wear corrective lenses for seeing far away

☐ I wear corrective lenses for seeing close up

☐ I wear contacts ☐ I wear glasses

Color Vision

Attach Completed Hardy, Rand, and Rittler (HRR) COLOR VISION SCORE SHEET

Depth Perception (check test used)

☐ **Titmus**

☐ **Other** **(Please Specify)** _____

Number of correct responses

____ of ____ total number

____ Seconds of Arc

OR

____% Shepard-Fry

Peripheral Vision

Right		**Normal Range**
Temporal	_____°	85-90°
Nasal	_____°	35-50°
Total	_____°	

Left		
Temporal	_____°	85-90°
Nasal	_____°	35-50°
Total	_____°	

ATTENTION EXAMINER: Contact wearers must remove contacts for all uncorrected vision.

NOTE: MUST TEST BOTH UNCORRECTED AND CORRECTED VISION

UNCORRECTED VISION (SNELLEN UNITS)

Far Vision Both 20/ ____ Right 20/ ____ Left 20/ ____

Near Vision Both 20/ ____ Right 20/ ____ Left 20/ ____

CURRENT CORRECTED VISION (SNELLEN UNITS)

Far Vision Both 20/ ____ Right 20/ ____ Left 20/ ____

Near Vision Both 20/ ____ Right 20/ ____ Left 20/ ____

NOTE: IF THE VISION TESTING METHOD ONLY TESTS TO 20/200, STATE: "WORSE THAN 20/200." DO NOT USE SYMBOLS (EXAMPLE: < OR >) TO DENOTE THAT CIRCUMSTANCE.

VISION COMMENTS: _____

_____

_____

_____

Printed Name of Examiner	Telephone Number	Signature	Date

APPLICANT'S NAME:	SSN:	DATE:

TUBERCULOSIS SCREENING

FOLLOW INSTRUCTIONS FOR EACH QUESTION	CIRCLE Yes or No	Action	FACILITY USE ONLY
1. Have you ever had a positive TB skin test? **(IF YES, PLEASE COMPLETE LOWER RIGHT SECTION OF THIS FORM AND SUBMIT A CHEST XRAY REPORT FROM PAST 6 MONTHS)** **(DO NOT PERFORM CHEST X-RAY IF EXAMINEE IS OR MAY BE PREGNANT.)**	YES → NO →	STOP Go to Q #2	**DO NOT TEST. PERFORM 1 VIEW CHEST X-RAY *OR* SUBMIT RECENT (W/IN 6 MO.) CHEST X-RAY REPORT** If symptoms of TB (see Q #4), refer to PMD for evaluation
2. Have you had a viral infection (e.g. flu, measles, etc.) or have you received a live virus flu vaccination in the last 6 weeks?	YES → NO →	STOP Go to Q #3	**DEFER TESTING** Have examinee complete Q 3-5. Save form and plan to test client after well for 6 weeks
3. Have you had symptoms of tuberculosis within the last 6 months? a. Coughing up blood 2-3 weeks OR b. Do you have two or more of the following? Chronic cough Soaking night sweats Fever (>100) Chronic fatigue Unexplained weight loss	YES → NO →	STOP Go to Q #4	**TEST** Have examinee complete Q #4 and 5. Refer to PMD for evaluation
4. Does any of the following apply to you? a. HIV positive b. Close contact with known active TB c. Immunosuppression: such as organ transplant, daily oral prednisone d. An abnormal chest x-ray consistent with prior TB	YES → NO →	STOP Go to Q #5	**TEST** Read test positive at 5 mm
5. Does any of the following apply to you? a. Recent arrival (less than 5 yrs) from high prevalence countries (ignore BCG history)	YES →	STOP	**TEST** Read test positive at 10 mm
b. Use injectable drugs (IV drug user) c. Work or reside in high-risk setting (e.g. prisons, and jails, nursing homes and other long-term facilities for elderly; hospitals and other health care facilities, residential facilities for patients with AIDS, homeless shelters, mycobacteriology labs) d. Have one or more of the following clinical conditions: silicosis, diabetes, chronic renal failure, some hematologic disorders, (e.g. leukemia or lymphoma), other specific malignancies (e.g. carcinoma of head or neck and lung), gastrectomy, jejeunoileal bypass, weight loss of 10% or more from ideal body weight	NO →	STOP	**TEST** Read test positive at 15 mm
6. **I understand I MUST return to have test read in 48-72 hrs**	YES		

I **decline** to receive the tuberculosis skin test _____ Reason: _____

(Employee Signature)

DOCUMENTATION OF SCREENING/RESULTS			
Check ONE	**PPD RESULTS**		**PAST POSITIVE PPD DETAILS**
☐ PPD NOT Indicated (positive Hx)	Date applied:_____	Date Read: _____	Date positive: _____
	Applied by: _____	Read by: _____	mm induration:
☐ PPD applied	Manufacturer: _____	mm induration: _____	INH taken: ☐YES ☐NO
	Lot # _____		If yes, dates:
☐ Client declined test	Exp_____		Last chest x-ray: Date:_____ Result:
If history or current test is POSITIVE, attach chest x-ray report (DO NOT SEND FILM) performed in last 6 months ☐ **Chest x-ray report attached**			
Check if applicable: ☐ Client referred for symptoms ☐Client did not return for reading (_____) signature and title			