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 ☐ Native ☐ Naturalized ☐ Alien

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 _____

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Vision:

Right with glasses __/20 without glasses _____/20 **Left** with glasses _____/20 without glasses _____/20

Past Medical History (for additional space use back page

		Yes	No	Not Sure
1	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).	☐	☐	☐
2	Have you ever been treated for a nervous condition? (If yes, specify when, where and give details)	☐	☐	☐
3	Have you ever been denied life insurance? (If yes, state reason and give details)	☐	☐	☐
4	Have you had, or have you been advised to have any operations (If yes, describe and give age)	☐	☐	☐
5	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)	☐	☐	☐
6	Date of last physical _____; Date of last hospitalization _____; No. of days _____			
7	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)	☐	☐	☐
8	Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, Give date and reasons for rejection).	☐	☐	☐
9	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).	☐	☐	☐
10	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).	☐	☐	☐
11	Weight at age 18: _____			
12	Have you ever:			
	Lived with anyone who had tuberculosis?	☐	☐	☐
	Coughed up blood?	☐	☐	☐
	Bled excessively after injury or tooth extraction?	☐	☐	☐
	Attempted suicide?	☐	☐	☐
	Been a sleepwalker?	☐	☐	☐
13	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?	☐	☐	☐

Have you ever had or have you now (please check at right of each item). NS*- Not Sure

	Yes	No	NS*		Yes	No	NS*		Yes	No	NS*
Scarlet fever	☐	☐	☐	Emphysema	☐	☐	☐	"Trick" or locked knee	☐	☐	☐
Rheumatic fever	☐	☐	☐	Limit of joint motion	☐	☐	☐	Foot trouble	☐	☐	☐
Swollen or painful joints	☐	☐	☐	Cramps in your legs	☐	☐	☐	Neuritis	☐	☐	☐
Frequent or severe headache	☐	☐	☐	Gall bladder trouble (gallstones)	☐	☐	☐	Paralysis (include infantile)	☐	☐	☐
Dizziness/fainting spells	☐	☐	☐	Jaundice or Hepatitis	☐	☐	☐	Epilepsy or fits	☐	☐	☐
Eye trouble	☐	☐	☐	Tuberculosis	☐	☐	☐	Car, train, sea or air sickness	☐	☐	☐
Ear, nose or throat trouble	☐	☐	☐	Broken bones	☐	☐	☐	Frequent trouble sleeping	☐	☐	☐
Hearing loss	☐	☐	☐	Tumor, growth, cyst, cancer	☐	☐	☐	Depression or excessive worry	☐	☐	☐
Chronic or frequent colds	☐	☐	☐	Rupture/hernia	☐	☐	☐	Loss of memory or amnesia	☐	☐	☐
Severe tooth/gum trouble	☐	☐	☐	Piles or rectal disease	☐	☐	☐	Nervous trouble of any sort	☐	☐	☐
Sinusitis	☐	☐	☐	Frequent/painful urination	☐	☐	☐	Periods of unconsciousness	☐	☐	☐
Hay fever	☐	☐	☐	Bed wetting since age 12	☐	☐	☐	Gout	☐	☐	☐
Head injury	☐	☐	☐	Kidney stones or blood in urine	☐	☐	☐	Hardening of arteries	☐	☐	☐
Skin diseases	☐	☐	☐	Sugar or albumin in urine	☐	☐	☐	Anemia/blood disorder	☐	☐	☐

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	Yes	No	NS*		Yes	No	NS*		Yes	No	NS*
Thyroid trouble	☐	☐	☐	STD – syphilis, gonorrhea	☐	☐	☐	Glaucoma	☐	☐	☐
Adverse reaction to serum, Drug, medicine or foods	☐	☐	☐	Frequent indigestion, stomach ulcer	☐	☐	☐	Stomach, liver or intestinal trouble	☐	☐	☐
Asthma	☐	☐	☐	Recent weight gain or loss	☐	☐	☐	Abnormal chest X-ray	☐	☐	☐
Shortness of breath	☐	☐	☐	Arthritis, rheumatism, or bursit	☐	☐	☐	Abnormal G.I. X-ray	☐	☐	☐
Pain or pressure in chest	☐	☐	☐	Bone, joint or other deformity	☐	☐	☐	Abnormal EKG	☐	☐	☐
Chronic cough	☐	☐	☐	Lameness	☐	☐	☐	Use tobacco	☐	☐	☐
Palpitation/pounding heart	☐	☐	☐	Loss of finger or toe	☐	☐	☐	Use alcohol	☐	☐	☐
Heart Trouble	☐	☐	☐	Kidney/bladder trouble	☐	☐	☐	Recurrent back pain	☐	☐	☐
High or low blood pressure	☐	☐	☐	Herpes	☐	☐	☐	Painful or “trick” shoulder or Elbow	☐	☐	☐
Bronchitis	☐	☐	☐	FEMALES ONLY: Have you ever							
				Been treated for a female Disorder	☐	☐	☐				
				Had a change in menstrual Pattern?	☐	☐	☐				

NS*- Not Sure

Immunizations

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

	Yes	No	NS*	Date		Yes	No	NS*	Date		Yes	No	NS*	Date
Tetanus	☐	☐	☐		BCG (TB)	☐	☐	☐		Gamma Globulin	☐	☐	☐	
Smallpox	☐	☐	☐		Cholera	☐	☐	☐		Diphtheria	☐	☐	☐	
Yellow Fever	☐	☐	☐		Typhoid	☐	☐	☐		Malaria	☐	☐	☐	
Plague	☐	☐	☐		Typhus	☐	☐	☐		Other	☐	☐	☐	

NS*- Not Sure

Other

Please provide any relevant details or additional conditions:

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Medical Advisory Systems/ MedAire Combined Medical Release, Consent for Release of Medical Information and Authorization for Release of Medical Information – The following language combines wording of a standard medical release required by Medical Advisory Systems, Inc. and language required by the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*.

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: _____

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_____
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:

Description of Record	Person Making Request	Authorization Expiration Date
_____	_____	_____

I also authorize Medical Advisory Systems/ MedAireto 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:

Description of Record	Person Making Request	Authorization Expiration Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

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.)

_____ _____
Employee signature (Witness to employee signature)

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Document Number: