Military Sealift Command Mariner Medical Screening Questionnaire

MSC is very interested in CIVMAR health and wellbeing. MSC Force Medical strongly encourages all CIVMARs to optimally manage their personal medical and dental problems in conjunction with their primary healthcare and dental providers. Your health affects you, your shipmates and the mission.

New hire and periodic fitness for duty screenings require completion of all elements of this questionnaire.

Last: MI: First: Last 4:

Email: Phone number:

How often do you visit the doctor? List any medical conditions you have or any health issues that are currently under evaluation:

Do you now have or have you ever had any of the following? These are NOT necessarily disqualifying but may require further clarification

Please select either YES or NO:

1	Changes in vision, blurry vision, poor night vision, eye disease or injury, eye surgery, abnormal color vision, cataracts or glaucoma	YES/NO Select
2	Changes in hearing, hearing loss, hearing aid, ear surgery, facial deformities or open tracheostomy	YES/NO Select
3	History of high or low blood pressure	YES/NO Select
4	Heart or vascular disease of any kind (to include heart murmur, angina, chest pain, irregular heartbeat, heart valve problem/replacement, heart attack/myocardial infarction or congestive heart failure)	YES/NO Select
5	Heart surgery and/or implanted devices (for example angioplasty, stent, pacemaker, defibrillator	YES/NO Select

6	Lung disease of any type (for example bronchitis, asthma, emphysema, chronic obstructive pulmonary disease [COPD], tuberculosis [TB]). Do you have shortness of breath, wheezing, been prescribed or used an inhaler or any breathing problems related to exercise, weather, pollens, etc	YES/NO Select
7	Any blood disorder (for example anemia, Sickle Cell Disease, hemophilia, blood clots, polycythemia), frequent severe nosebleeds or prolonged bleeding [as after an injury or tooth extraction, etc])	YES/NO Select
7a	Blood/Lymph cancer (for example leukemia, lymphoma, multiple myeloma)	YES/NO Select
8	Diabetes, glucose intolerance or sugar in urine. Recent unexplained weight loss or gain	YES/NO Select
9	Thyroid problem (requiring treatment or hospitalization) or goiter	YES/NO Select
10	Stomach/gastric, liver or intestinal disorder requiring ongoing medical care/medication or causing significant bleeding or debilitating pain; history of hepatitis, jaundice, gall bladder trouble or gallstones, rupture/hernia, frequent indigestion/heartburn, rectal disease, hemorrhoids or blood from the rectum	YES/NO Select
11	Kidney/renal problems, kidney stones, blood in urine or frequent/painful urination	YES/NO Select
12	Any other urinary or bladder problems not listed above requiring treatment or hospitalization	YES/NO Select
13	Skin disorders requiring medical treatment (for example cancers, tumors, scleroderma, lupus, psoriasis, acne, eczema)	YES/NO Select
13a	Active or history of facial shave bumps (pseudo folliculitis barbae/PFB)?	YES/NO Select
14	Severe allergies or allergic reactions to any substance (medication, food, insect stings or other)	YES/NO Select
14a	Autoimmune disorders (for example rheumatoid arthritis, lupus, celiac, multiple sclerosis [MS], Sjogrens, ankylosing spondylitis)	YES/NO Select
14b	Bowel disease (for example Inflammatory Bowel Disease [IBD], Irritable Bowel Syndrome [IBS], Crohns disease)	YES/NO Select
15	Communicable or chronic infectious diseases (such as tuberculosis [TB], HIV/AIDS, hepatitis)	YES/NO Select
16	Any sleep problems (for example obstructive sleep apnea [OSA], restless leg syndrome [RLS], narcolepsy, shift work sleep disorder, insomnia)	YES/NO Select
17	History of epilepsy, fits, seizures, meningitis or encephalitis	YES/NO Select

18	History of serious head injury, concussion, loss of consciousness, memory loss, amnesia or neurological symptoms	YES/NO Select
19	Frequent or severe headaches; migraines	YES/NO Select
20	Dizziness, fainting spells or balance problems	YES/NO Select
21	Frequent motion sickness (car, train, sea or air) requiring medication	YES/NO Select
22	Stroke, transient ischemic attack (TIA), brain tumor or other brain disorder	YES/NO Select
23	Any neurologic disorder or nerve problems (including numbness, tingling, paralysis, habitual stammering or stuttering)	YES/NO Select
24	Attention deficit disorder with or without hyperactivity (list all medication taking for diagnosis)	YES/NO Select
25	History of anxiety, depression, bipolar disorder, adjustment disorder, post-traumatic stress disorder (PTSD), schizophrenia, excessive worry, panic attacks or nervous trouble of any sort	YES/NO Select
26	History of suicide attempt or thought(s) of suicide	YES/NO Select
27	Evaluation, treatment, hospitalization or received counseling for alcohol or substance use, abuse, addiction or dependence (including illegal drugs, prescription medications or other substances)	YES/NO Select
28	Any other psychiatric disorder or mental health evaluation/treatment/hospitalization	YES/NO Select
29	Back, neck or joint problems that impair movement or cause debilitating or recurrent pain (such as deformity, arthritis, rheumatism, bursitis)	YES/NO Select
30	Amputation, prosthesis, or use of ambulatory devices (including a cane, walker or other). Any need to use corrective devices (such as prosthetics, brace[s], back support[s], lifts, orthotics, etc)	YES/NO Select
31	Injuries, fractures or recurrent dislocations causing impairment or limitation of motion of any joint	YES/NO Select
32	Have you ever been signed off a vessel as sick or repatriated for medical reasons within the last six years	YES/NO Select
33	Any diseases, surgeries, tumor, growth, cyst or cancer, illnesses or disabilities not listed on this form	YES/NO Select

34	Any hospital admissions within the last six years not listed elsewhere in this form	YES/NO Select
35	Current/untreated dental issues and/or poor dental health	YES/NO Select
36	Tooth problems, gum problems or tooth/gum pain	YES/NO Select
37	Have you been refused employment, been unable to hold a job or stay in school because of: a. Sensitivity to chemicals, dust, sunlight, etc b. Inability to perform certain motions c. Inability to stand, sit, kneel, lie down, etc d. Other medical reasons (if yes, give reasons below)	YES/NO Select
38	Have you ever been treated in an Emergency Room? If yes, when and for what?	YES/NO Select
38a	Have you had any surgeries? If yes, when and for what?	YES/NO Select
38b	Have you been advised to have any surgery or operations? If yes, when and for what?	YES/NO Select
39	Have you ever had any illness or injury other than those already noted? If yes, specify when, where and give details	YES/NO Select
40	Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses?	YES/NO Select
41	Have you ever been rejected or discharged from military service for any reason? If yes, give date, reason, and type of discharge (honorable, other than honorable, etc)	YES/NO Select
42	Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury?	YES/NO Select
43	Have you ever been denied life insurance?	YES/NO Select
44	**FEMALES ONLY**. a. Have you ever had or are you currently undergoing treatment for a gynecological (female) disorder b. Have you recently or currently had a change in menstrual pattern c. Are you pregnant?	YES/NO Select YES/NO Select YES/NO Select

45	History of tuberculosis (TB), positive PPD, coughed up blood, a chronic cough, cough at night or lived with someone with tuberculosis	YES/NO Select
46	History of ear, nose, or throat issues, chronic or frequent colds, hay fever or sinusitis	YES/NO Select
47	Foot issues (such as pain, corns, bunions, etc); shoulder, elbow, wrist, knee issues (such as pain, fracture, dislocation, etc) Knee or foot surgery including arthroscopy or the use of a scope to any bone or joint. Knee trouble (such as locking, giving out, pain or ligament injury, etc). Broken bone(s) (cracked or fractured), plate(s), screw(s), rod(s) or pin(s) in any bone	YES/NO Select
48	Do you use tobacco products?	YES/NO Select
49	Have you had any new medical problems?	YES/NO Select
50	Would you like to speak with an MSC Nurse to discuss any questions or to clarify anything on this form?	YES/NO Select

Explanation to ALL "YES" answers (indicate the question number):

List all medications that are currently prescribed to you: (medication name, dose, frequency taken and reason for taking)

Provide current: Height_____Weight_____

If I am a new hire candidate/applicant, I understand I must provide a current Tuberculin Skin Test (**TST/PPD or QFT**). If positive or a PPD converter, I must provide documentation of current or past treatment for latent tuberculosis infection (LTBI) **WITH** recent chest x-ray results. I must also provide documentation of **MMR#1, MMR#2, Polio** (titers indicating immunity for each is acceptable) and **COVID-19 #1, and COVID-19 #2 and COVID-19 Booster** vaccination status. I will also provide a copy of my VA Disability Rating to include medical conditions rated, if applicable.

_____ (Initial)

I understand that in accurately answering the pre-screening questions and/or failing to disclose the requested medical information may result in MSC rescinding the offer of employment. I also understand that should any of these conditions be newly discovered during this process, I may be directed to complete any medical follow-up requirements.

_____ _____ _____

(Print First Name and Last Name) (Signature) (Date)

PRIVACY ACT NOTICE OF 1974 and DoD PRIVACY REGULATION This document may contain information covered under the Privacy Act, 5 USC 552(a), and it's various implementing regulations and must be protected in accordance with those provisions. Personal information can be sensitive and must be treated accordingly. This correspondence is provided to you after appropriate authorization from the patient or under circumstances that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Redisclosure without additional patient consent or as permitted by law is prohibited. Unauthorized redisclosure or failure to maintain confidentiality subjects you to application of appropriate sanction. If you have received this correspondence in error, please notify the sender at once and destroy any copies you may have.

THIS SECTION FOR MSC INTERNAL USE ONLY

Case Review completed: _____ (date)

Additional Info needed (if any):

_____

_____

Duty Status and Date: _____ * / **

* Please see SF-600 entry

** **MSC Medical has final authority for MSC CIVMAR sea-duty medical status determination**

Reviewer's Comments:

Review and Endorsement Signatures: