Prototype Input and Output Data Elements for the Occupational Health and Safety Information System

Adrienne A. Whyte, Ph.D.

November 1980

Prepared for

Office of Occupational Health
National Aeronautics and Space Administration
Washington, D.C. 20546

Contract NASW-3119

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The National Aeronautics and Space Administration plans to implement a NASA-wide computerized information system for occupational health and safety. The system is necessary to administer the occupational health and safety programs and to meet the legal and regulatory reporting, recordkeeping, and surveillance requirements. The requirements for the information system were documented in an earlier report, *Information Requirements of the National Aeronautics and Space Administration's Safety, Environmental Health, and Occupational Medicine Program* (Whyte, 1978).

This report is intended to illustrate some of the potential data elements that NASA will require as input and output for the new occupational health and safety information system. The data elements are shown on sample forms that have been compiled from various sources, including NASA Centers and industry. These forms are grouped into categories that were defined in the Shirey report (1980), *NASA Safety and Health Information System*.

The data elements on these forms do not represent the complete set of elements that will be required in these categories. Rather, they represent the level of detail that NASA seeks in the new information system. When the system is implemented, some elements on these forms may be dropped, and others may be added.

A previous report, *Supporting Documentation for the Occupational Medicine, Environmental Health, and Safety Information System Project* (Whyte, 1979), also addressed data collection requirements for the new information system. Data elements were listed for the medical history, physical examination, laboratory tests, noise exposure data and audiometric tests, physical examination scheduling, occupational accidents and injuries, and safety and environmental health inspections and abatements.

The formats of the sample forms in this report are not recommended for either worksheets or screen input templates in the new system. It is expected that input formats will be developed by the successful system vendor, and that NASA will use the existing formats whenever possible.

Some of the forms in this report were developed by private organizations. Permission to reproduce those forms has been obtained.

References

Shirey, R.W. *NASA Safety and Health Information System.* Prepared for the National Aeronautics and Space Administration, Contract No. NAS5-26060, by the MITRE Corporation, MTR-80W114, 1980.

Whyte, A.A. *Information Requirements of the National Aeronautics and Space Administration's Safety, Environmental Health, and Occupational Medicine Programs.* Prepared for the National Aeronautics and Space Administration, Contract No. NASW-3119, by BioTechnology, Inc., 1978.

Whyte, A.A. *Supporting Documentation for the Occupational Medicine, Environmental Health, and Safety Information Systems Project.* Prepared for the National Aeronautics and Space Administration, Contract No. NASW-3119, by BioTechnology, Inc., 1979.

Medical History Input

OCCUPATIONAL HEALTH AND MEDICAL SURVEILLANCE

OHMS

MEDICAL

HISTORY

A SERVICE OF AMERICAN BIOMEDICAL CORPORATION

IN COOPERATION WITH MEDI-TECH, INCORPORATED

On the following pages, you will find questions about your health and medical background. The questions are designed to assist the doctors in protecting your health. Your answers and the medical tests will help in finding your health problems. The questions and tests are designed to detect early signs of harmful effects of exposures in your work place so that protective measures can be taken.

The information you provide will be used only by the medical department.

Although the questions are spread over several pages, you will probably find that they can be answered quickly and easily. Please read them carefully and enter your answers within the proper squares. Don't be concerned about complicated medical words. If you don't recognize the words, you probably haven't had the problem. Be as accurate as you can. It's for your protection.

Today's Date ___ ___ ___
Mo Day Yr

EMPLOYEE HEALTH TESTING

Identification Number

800 **Race** 1. ☐ White 2. ☐ Black 3. ☐ Other

900 **Marital status now**
1. ☐ SINGLE?
2. ☐ MARRIED ONCE ONLY?
3. ☐ WIDOWED?
4. ☐ DIVORCED?
5. ☐ SEPARATED?
6. ☐ MARRIED MORE THAN ONCE?

1000 **Do you have dependent children?** ☐ Yes ☐ No

1100 IF YES, HOW MANY? 1.☐ 2.☐ 3.☐ 4.☐ 5.☐ 6.☐ OR MORE

1200 **How far did you go in school?**
1. ☐ GRADE SCHOOL ONLY?
2. ☐ SOME HIGH SCHOOL?
3. ☐ HIGH SCHOOL GRADUATE?
4. ☐ SOME COLLEGE OR TECH. SCHOOL?
5. ☐ COLLEGE OR TECH. SCHOOL GRADUATE?
6. ☐ SOME POST GRADUATE SCHOOL?
7. ☐ POST GRADUATE DEGREE?
8. ☐ STILL IN SCHOOL?

1300 **Length of time on present job?** 1. ☐ Under 1 Yr. 2. ☐ 1-5 Yrs. 3. ☐ 5-10 Yrs. 4. ☐ Over 10 Yrs. 5. ☐ New Employee

1400 **Have you ever been rejected for insurance, military service or employment because of your health?**

1500 **Have you ever received compensation for work-related illness or injury?** ☐ Yes ☐ No

1600 **Do you have any religious beliefs that could affect your medical care?** ☐ Yes ☐ No

1700 **During the past year were you off work because of injury or illness?** ☐ Yes ☐ No

1780 IF YES, HOW MANY DAYS FOR ILLNESS?
1. ☐ LESS THAN 7 DAYS?
2. ☐ 8-14 DAYS?
3. ☐ 15-30 DAYS?
4. ☐ OVER 30 DAYS?
5. ☐ NONE?

1790 HOW MANY DAYS FOR INJURY?
1. ☐ LESS THAN 7 DAYS?
2. ☐ 8-14 DAYS?
3. ☐ 15-30 DAYS?
4. ☐ OVER 30 DAYS?
5. ☐ NONE?

1800 **In your work, do you frequently encounter**
1. ☐ VERY HIGH NOISE LEVELS?
2. ☐ IRRITATING FUMES?
3. ☐ BOTHERSOME DUSTS?
4. ☐ THINGS YOU ARE ALLERGIC TO?
5. ☐ TOXIC SUBSTANCES OR SOLUTIONS?
6. ☐ UNUSUAL HEAT?
7. ☐ HAZARDOUS ACTIVITIVES (HIGH VOLTAGE, EXPLOSIVES, ETC.)?
8. ☐ NONE OF THESE?

1900 **Do you stand continuously in your work?** ☐ Yes ☐ No

2000 **Or do you work in cramped or uncomfortable positions?** ☐ Yes ☐ No

EMPLOYEE HEALTH TESTING

Identification Number

2100 **Is your mother living?** ☐ Yes ☐ No ☐ Don't Know

2200 **Age, if living**
1. ☐ 35-45
2. ☐ 46-55
3. ☐ 56-65
4. ☐ 66-70
5. ☐ OVER 70

2300 **If deceased, age at death**
1. ☐ BEFORE AGE 35
2. ☐ 35-45
3. ☐ 46-55
4. ☐ 56-65
5. ☐ 66-70
6. ☐ OVER 70

2350 **Did she die of**
1. ☐ CANCER
2. ☐ HEART DISEASE
3. ☐ STROKE
4. ☐ ACCIDENT
5. ☐ OTHER CAUSE

(1)

2400 **Is your father living?** ☐ Yes ☐ No ☐ Don't Know

2500 **Age, if living**
1. ☐ 35-45
2. ☐ 46-55
3. ☐ 56-65
4. ☐ 66-70
5. ☐ OVER 70

2600 **If deceased, age at death**
1. ☐ BEFORE AGE 35
2. ☐ 35-45
3. ☐ 46-55
4. ☐ 56-65
5. ☐ 66-70
6. ☐ OVER 70

2650 **Did he die of**
1. ☐ CANCER
2. ☐ HEART DISEASE
3. ☐ STROKE
4. ☐ ACCIDENT
5. ☐ OTHER CAUSE

2700 **Have any brothers or sisters, aunts or uncles died before the age of 50?** ☐ Yes ☐ No ☐ Don't Know

2800 **Have any of your blood relatives** *(Parents, Grandparents, Brothers or Sisters, Aunts or Uncles, or Children)* **Had any of the following diseases?**

1. ☐ NO KNOWLEDGE OF BLOOD RELATIVES?
2. ☐ DIABETES?
3. ☐ STROKE?
4. ☐ HEART DISEASE?
5. ☐ HIGH BLOOD PRESSURE?
6. ☐ TUBERCULOSIS?
7. ☐ EPILEPSY?
8. ☐ DEAFNESS UNDER 60 YRS. OF AGE?
9. ☐ NONE OF THESE

2900 **Or any of these**

1. ☐ CANCER?
2. ☐ ALLERGIC DISEASE?
3. ☐ GOUT?
4. ☐ SUICIDE?
5. ☐ ALCOHOLISM?
6. ☐ MENTAL DISEASE?
7. ☐ BLOOD DISEASE?
8. ☐ OVER WEIGHT?
9. ☐ NONE OF THESE?

EMPLOYEE HEALTH TESTING

Identification Number _____

	Have you had any of these diseases →		Check any which have caused permanent damage or continuing trouble	
3000	1. ☐	PARASITES, WORMS OR AMOEBA	1. ☐	3100
	2. ☐	PNEUMONIA	2. ☐	
	3. ☐	MEASLES	3. ☐	
	4. ☐	GERMAN MEASLES	4. ☐	
	5. ☐	MUMPS	5. ☐	
	6. ☐	SCARLET FEVER	6. ☐	
	7. ☐	RHEUMATIC FEVER	7. ☐	
	8. ☐	MALARIA	8. ☐	
	9. ☐	NONE OF THESE	9. ☐	

	Or any of these →		(Continuing trouble)	
3200	1. ☐	POLIO	1. ☐	3300
	2. ☐	DIABETES	2. ☐	
	3. ☐	MENNINGITIS OR ENCEPHALITIS	3. ☐	
	4. ☐	TUBERCULOSIS	4. ☐	
	5. ☐	INFECTIOUS MONONUCLEOSIS	5. ☐	
	6. ☐	NEPHRITIS OR BRIGHTS DISEASE	6. ☐	
	7. ☐	MIGRAINE HEADACHES	7. ☐	
	8. ☐	NONE OF THESE	8. ☐	

02

	or these →		(Continuing trouble)	
3400	1. ☐	EPILEPSY, FITS OR CONVULSIONS	1. ☐	3500
	2. ☐	GOUT OR ARTHRITIS	2. ☐	
	3. ☐	LEUKEMIA OR OTHER BLOOD DISEASE	3. ☐	
	4. ☐	MENTAL ILLNESS/NERVOUS BREAKDOWN	4. ☐	
	5. ☐	DEPRESSION REQUIRING TREATMENT	5. ☐	
	6. ☐	ALCOHOLISM OR CIRRHOSIS	6. ☐	
	7. ☐	PEPTIC ULCER	7. ☐	
	8. ☐	NONE OF THESE	8. ☐	

EMPLOYEE HEALTH TESTING

Identification Number

3600 Have you ever had any surgical operations? ☐ Yes ☐ No

IF YES, CHECK THE OPERATIONS YOU HAVE HAD
3700

1. ☐ TONSILS AND ADENOIDS?
2. ☐ APPENDIX?
3. ☐ GALL BLADDER?
4. ☐ HERNIA?
5. ☐ HEMORRHOIDS?
6. ☐ VARICOSE VEINS?
7. ☐ D & C?
8. ☐ CAESARIAN SECTION?
9. ☐ NONE OF THESE?

3800 (OR THESE)

1. ☐ STERILIZATION (MALE OR FEMALE)?
2. ☐ PROSTATE?
3. ☐ STOMACH?
4. ☐ KIDNEY?
5. ☐ COLON OR RECTUM?
6. ☐ THYROID?
7. ☐ NONE OF THESE?

3900 (OR THESE)

1. ☐ LARYNX?
2. ☐ BREAST?
3. ☐ UTERUS OR WOMB, REMOVED OR REPAIRED?
4. ☐ PENIS OR TESTICLES?
5. ☐ SINUS OR NOSE?
6. ☐ JOINT OR BONE?
7. ☐ NONE OF THESE?

4000 Have you had other surgery, not listed? ☐ Yes ☐ No

4100 Has surgery been recommended which you have not had done? ☐ Yes ☐ No

4200 Have you ever had cancer or a malignant tumor? ☐ Yes ☐ No

4300 IF YES, WAS THIS A SKIN CANCER, ALONE? ☐ Yes ☐ No

4400 Have you had any treatments with X-ray, radium, cobalt or radioisotopes? ☐ Yes ☐ No

4500 Have you ever had broken bones or other injury which caused permanent deformity or disability? ☐ Yes ☐ No

4600 Or are you 1. ☐ Blind? 2. ☐ Totally Deaf? 3. ☐ Unable to Speak (Mute)? 4. ☐ An Amputee? 5. ☐ Paraplegic? 6. ☐ Disabled in Other Ways? 7. ☐ None of These?

4700 Check the immunizations or vaccinations which you have had.

1. ☐ SMALL POX, IN PAST 10 YRS.?
2. ☐ SMALL POX, OVER 10 YRS. AGO?
3. ☐ TETANUS, IN PAST 2 YRS.?
4. ☐ TETANUS, OVER 2 YRS. AGO?
5. ☐ WHOOPING COUGH?
6. ☐ DIPTHERIA?
7. ☐ POLIO (SHOTS)?
8. ☐ POLIO (BY MOUTH)?
9. ☐ NONE OF THESE?

4800 How about these

1. ☐ MEASLES?
2. ☐ GERMAN MEASLES?
3. ☐ INFLUENZA (IN THE PAST YEAR)?
4. ☐ TYPHOID?
5. ☐ RABIES?
6. ☐ GAMMA GLOBULIN (IMMUNE GLOBULIN)?
7. ☐ RHOGAM?
8. ☐ NONE OF THESE?

EMPLOYEE HEALTH TESTING

Identification Number _____

0100 **Are you now taking any medications regularly?** ☐ Yes ☐ No

0200 **Have you ever had an allergic reaction from medicine or from injections?** ☐ Yes ☐ No

0300 **Have you had any allergic illness like**

1. ☐ ASTHMA ?
2. ☐ HAY FEVER ?
3. ☐ HIVES ?
4. ☐ OTHER ALLERGIC ILLNESS ?
5. ☐ NONE ?

0400 IF SO, ARE YOU ALLERGIC TO

1. ☐ PLANTS (POISON IVY, ETC.)?
2. ☐ POLLENS (RAG WEED, ETC.)?
3. ☐ FOODS ?
4. ☐ ANIMALS ?
5. ☐ DUSTS OR FEATHERS ?
6. ☐ INSECT STINGS ?
7. ☐ SOMETHING ELSE ?
8. ☐ DON'T KNOW ?

0500 **Do you smoke cigarettes?** ☐ Yes ☐ No

0600 IF YES, TELL US HOW MANY,

1. ☐ 1/2 PACK OR LESS/DAY ?
2. ☐ 1/2 TO 1 PACK/DAY ?
3. ☐ 1 TO 2 PACKS/DAY ?
4. ☐ 2 OR MORE PACKS/DAY ?

0700 AND FOR HOW LONG

1. ☐ LESS THAN FIVE YEARS ?
2. ☐ FIVE TO TEN YEARS ?
3. ☐ TEN TO TWENTY YEARS ?
4. ☐ MORE THAN TWENTY YEARS ?

0800 IF NO, DID YOU PREVIOUSLY SMOKE REGULARLY? ☐ Yes ☐ No

0900 **Do you smoke marijuana?** ☐ Yes ☐ No

1000 IF YES, DO YOU AVERAGE, AT LEAST, ONE JOINT A DAY? 1. ☐
1-3 JOINTS A DAY? 2. ☐
OVER 3 JOINTS A DAY? 3. ☐
LESS THAN ANY OF THESE? 4. ☐

1100 **Do you drink alcoholic beverages?** ☐ Yes ☐ No

1200 IF YES, MARK THOSE ANSWERS WHICH ARE CORRECT

1. ☐ AVERAGE LESS THAN 3 DRINKS PER WEEK?
2. ☐ AVERAGE 3 TO 6 DRINKS PER WEEK?
3. ☐ AVERAGE 7 TO 24 DRINKS PER WEEK?
4. ☐ AVERAGE 24 TO 40 DRINKS PER WEEK?
5. ☐ AVERAGE MORE THAN 40 DRINKS PER WEEK?

1300 DO YOU

1. ☐ DRINK WINE
2. ☐ DRINK BEER
3. ☐ DRINK WHISKEY, VODKA, GIN OR OTHER HARD LIQUOR
4. ☐ DRINK MORE THAN YOU DID LAST YEAR

1400 DO YOU THINK YOU HAVE A DRINKING PROBLEM? ☐ Yes ☐ No

1500 **If you don't drink now, have you been a heavy drinker in the past?** ☐ Yes ☐ No

1600 IF YES, DID YOU STOP DRINKING BECAUSE YOU THOUGHT YOU HAD A DRINKING PROBLEM? ☐ Yes ☐ No

1700 ARE YOU A MEMBER OF A.A.? ☐ Yes ☐ No

EMPLOYEE HEALTH TESTING

Identification Number _____

6000 Do you take any hallucinogenic or hard drugs such as LSD, speed, heroin, cocaine, etc.? ☐ Yes ☐ No

6000 Is your job activity 1. ☐ Heavy Work? 2. ☐ Average Work? 3. ☐ Sedentary?

7000 Other than your job, how much exercise do you get?

1. ☐ STAIRS, LESS THAN 5 FLIGHTS OR WALK LESS THAN 1/2 MILE, 4 TIMES/WEEK, OR EQUIVALENT?
2. ☐ CLIMB 5-15 FLIGHTS OR WALK 1/2 - 1 1/2 MILES, 4 TIMES/WEEK, OR EQUIVALENT?
3. ☐ CLIMB 15-20 FLIGHTS OR WALK 1 1/2 - 2 MILES, 4 TIMES/WEEK, OR EQUIVALENT?
4. ☐ MORE EXERCISE THAN ANY OF THESE

7100 Are you following any special diet now? ☐ Yes ☐ No

7200 Do you eat at least 2 well balanced meals every day? ☐ Yes ☐ No

7300 Do you think you are definitely overweight? ☐ Yes ☐ No

IF YES.			Yes	No
	7400	ARE MOST OF YOUR FAMILY DEFINITELY OVERWEIGHT?	☐	☐
	7500	HAS OVERWEIGHT BEEN A LONG STANDING PROBLEM (10 YRS.)?	☐	☐
	7600	ARE YOU DIETING NOW?	☐	☐
	7700	DO YOU TAKE AN APPETITE SUPPRESSANT MEDICATION?	☐	☐
	7800	COULD YOU REDUCE TO NORMAL WEIGHT IF YOU HAD TO?	☐	☐
	7900	HAVE YOU HAD PROFESSIONAL HELP TO REDUCE?	☐	☐

8000 Has your weight changed as much as 10 pounds in the past year? ☐ Yes ☐ No

8100 IF YES, HAVE YOU 1. ☐ GAINED WEIGHT? 2. ☐ LOST WEIGHT? 3. ☐ OR BOTH, UP AND DOWN?

8200 IF LOST WEIGHT, HAS IT BEEN 1. ☐ BY DIET? 2. ☐ UNEXPLAINED? 3. ☐ DON'T KNOW?

8300 Do you think that you are in good health? ☐ Yes ☐ No

8400 Do you tire out or fatigue a lot more than one year ago? ☐ Yes ☐ No 04

8500 IF YES, IS THE FATIGUE 1. ☐ WORSE IN THE MORNING, TILL YOU GET GOING?
2. ☐ WORSE IN THE AFTERNOON OR EVENING?
3. ☐ PRESENT ALL OF THE TIME?
4. ☐ PRESENT BUT NOT ALL THE TIME?

8600 Do you regularly have fever or elevated temperature? ☐ Yes ☐ No

8700 IF YES, DO YOU ALSO HAVE SEVERE SWEATS AT NIGHT? ☐ Yes ☐ No

8800 Do you seem to have more colds or infections this year? ☐ Yes ☐ No

EMPLOYEE HEALTH TESTING

Identification Number

0000 **Have you ever been told by a doctor that you had sugar diabetes?** ☐ Yes ☐ No

0000 IF YES, DO YOU
1. ☐ FOLLOW A DIET FOR DIABETES?
2. ☐ TAKE INSULIN SHOTS DAILY?
3. ☐ TAKE A DIABETIC PILL DAILY?
4. ☐ HAVE TROUBLE CONTROLLING YOUR BLOOD SUGAR?
5. ☐ TEST YOUR URINE REGULARLY?
6. ☐ DO NOTHING ABOUT YOUR DIABETES?

0100 **Do you have**
1. ☐ INCREASED THIRST FOR WATER?
2. ☐ SHAKINESS OR WEAKNESS THAT GETS BETTER WHEN YOU EAT.
3. ☐ A LOT MORE SWEATING THAN YOU DID LAST YEAR?
4. ☐ MORE TROUBLE WITH COLD WEATHER THAN LAST YEAR?
5. ☐ MORE TROUBLE WITH HOT WEATHER THAN LAST YEAR?
6. ☐ ANY RECENT CHANGE IN FACIAL OR BODY HAIR?
7. ☐ NONE OF THESE?

0200 **Have you ever had a goiter or trouble with your thyroid?** ☐ Yes ☐ No

0300 **Do you wear glasses or contact lenses?** ☐ Yes ☐ No

0400 IF YES, ARE YOUR LENSES PLASTIC OR 'SAFETY' TYPE? ☐ Yes ☐ No

0500 **Do you have trouble with your eyes that cannot be corrected with glasses?** ☐ Yes ☐ No

0600 IF YES, DO YOU HAVE
1. ☐ A BLIND EYE?
2. ☐ AN ARTIFICIAL EYE?
3. ☐ CATARACTS?
4. ☐ GLAUCOMA?
5. ☐ DOUBLE VISION OR BLURRED VISION?
6. ☐ INFECTION OR IRRITATION OF EYES?
7. ☐ SOME OTHER PROBLEM?

0700 **Have you had a hearing test in the last two years?** ☐ Yes ☐ No

0800 IF YES, WAS YOUR HEARING TESTED AS NORMAL? ☐ Yes ☐ No ☐ Don't Know

0900 IF NO, WAS YOUR PROBLEM IN YOUR
1. ☐ RIGHT EAR?
2. ☐ LEFT EAR?
3. ☐ BOTH EARS?
4. ☐ NEITHER EAR OR DON'T KNOW?

10000 **Do you think your hearing is** 1. ☐ GOOD? 2. ☐ FAIR? 3. ☐ POOR?

Please answer next 6 questions

69

EMPLOYEE HEALTH TESTING

Identification Number

If hearing not good

10100 HAVE YOU JUST NOTICED A RECENT CHANGE? ☐ Yes ☐ No

10200 DO YOU WEAR A HEARING AID? ☐ Yes ☐ No

10300 DO YOU FREQUENTLY HAVE DRAINAGE FROM EITHER EAR? ☐ Yes ☐ No

10400 DO YOU GET EAR WAX THAT REDUCES YOUR HEARING? ☐ Yes ☐ No

10500 HAVE YOU HAD HEARING LOSS SINCE BIRTH OR SINCE CHILDHOOD ☐ Yes ☐ No

10600 HAS YOUR HEARING BEEN AFFECTED BY NOISE EXPOSURE? ☐ Yes ☐ No

10700 **Have you had any other sort of ear trouble, not hearing loss?** ☐ Yes ☐ No

10800 IF YES, IS IT
1. ☐ RINGING OR BUZZING IN EITHER EAR?
2. ☐ TROUBLE WITH EAR INFECTIONS OR EAR PAIN?
3. ☐ PREVIOUS SURGERY ON YOUR EAR OR 'MASTOIDS'?
4. ☐ EAR WAX?
5. ☐ SOME OTHER PROBLEM?

10900 **Do you have**
1. ☐ PAINFUL SINUS INFECTIONS?
2. ☐ FREQUENT STUFFY OR RUNNY NOSE?
3. ☐ FREQUENT SNEEZING?
4. ☐ BOTHERSOME DRAINAGE IN THE BACK OF YOUR THROAT?
5. ☐ NOSEBLEEDS NOT DUE TO INJURY?
6. ☐ TROUBLESOME NASAL OBSTRUCTION?
7. ☐ NONE OF THESE?

11000 **Do you have**
1. ☐ FREQUENT SORE THROATS (MORE THAN 4 OR 5 A YEAR)?
2. ☐ SORES OR LUMPS IN YOUR LIPS, MOUTH OR TONGUE?
3. ☐ DENTURES OR FALSE TEETH?
4. ☐ SERIOUS TROUBLE WITH YOUR TEETH OR BLEEDING GUMS?
5. ☐ PERSISTENT HOARSENESS EXCEPT WITH COLDS?
6. ☐ TROUBLE SWALLOWING?
7. ☐ NONE OF THESE?

11100 **Do you have a regular, everyday cough?** ☐ Yes ☐ No

11200 IF YES, IS THE COUGH
1. ☐ JUST WITHIN THE LAST FEW MONTHS?
2. ☐ PRESENT FOR SEVERAL YEARS?
3. ☐ SEASONAL?
4. ☐ DUE TO SMOKING?
5. ☐ NONE OF THESE?

11300 IF YES, DO YOU COUGH UP
1. ☐ BLOOD OR BLOODY MUCOUS?
2. ☐ YELLOW OR GREEN MATERIAL?
3. ☐ LARGE AMOUNTS OF SPUTUM, MUCOUS OR PHLEGM?
4. ☐ NONE OF THESE?

EMPLOYEE HEALTH TESTING

Identification Number

11600 **Have you had a chest x-ray within the last year?** ☐ Yes ☐ No

- 11800 IF YES, WAS IT ABNORMAL IN ANY WAY? ☐ Yes ☐ No ☐ Don't Know
  - 11900 IF YES, WAS IT REPORTED TO BE
    1. ☐ TUBERCULOSIS?
    2. ☐ PNEUMONIA?
    3. ☐ EMPHYSEMA?
    4. ☐ CHRONIC BRONCHITIS?
    5. ☐ SCARRING OR FIBROSIS?
    6. ☐ FUNGUS OR YEAST INFECTION?
    7. ☐ TUMOR OR CYST?
    8. ☐ SOMETHING ELSE?

11700 **Have you had a skin test for tuberculosis within the past one year** ☐ Yes ☐ No

- 11800 IF YES, WAS IT REPORTED TO BE NORMAL? ☐ Yes ☐ No ☐ Don't Know

11900 **Do you often have wheezing or whistling in your chest?** ☐ Yes ☐ No

- 12000 IF YES, DO YOU HAVE ASTHMA? ☐ Yes ☐ No

12100 **Have you had any serious chest or lung disease that hasn't been mentioned** ☐ Yes ☐ No

12200 **Are you so bothered by shortness of breath that you must stop what you are doing in your ordinary daily activity?** ☐ Yes ☐ No

- 12300 IF YES, ARE YOU SHORT OF BREATH WITH
  1. ☐ WALKING ON LEVEL GROUND?
  2. ☐ CLIMBING ONE FLIGHT OF STAIRS?
  3. ☐ ONLY HEAVIER EXERTION?
  4. ☐ SITTING OR NO ACTIVITY?
- 12400 IF YES, DO YOU
  1. ☐ PROP YOURSELF UP WITH PILLOWS TO SLEEP?
  2. ☐ AWAKE FROM SLEEP SMOTHERING OR WITH SEVERE SHORTNESS OF BREATH?
  3. ☐ NEITHER?

12500 **Are you bothered by chest discomfort — either pain, pressure or tightness** ☐ Yes ☐ No

- 12600 IF YES, DO YOU REGULARLY GET CHEST PAIN WITH PHYSICAL ACTIVITY OR WITH ANGER? ☐ Yes ☐ No
- 12700 IF YES, AT THESE TIMES DO YOU HAVE
  1. ☐ HEART POUNDING, RACING OR SKIPPING?
  2. ☐ SWEATING?
  3. ☐ SHORTNESS OF BREATH OR COUGH?
  4. ☐ WEAKNESS OR LIGHTHEADEDNESS?
  5. ☐ NONE OF THESE?
- 12800 IF YES, HAVE YOU HAD THESE PROBLEMS JUST WITHIN THE PAST YEAR? ☐ Yes ☐ No

EMPLOYEE HEALTH TESTING

Identification Number

12900 **Have you ever been told by your doctor that you had high blood pressure?** ☐ Yes ☐ No

13000 IF YES, ARE YOU TAKING MEDICINE FOR YOUR BLOOD PRESSURE? ☐ Yes ☐ No

13100 **Have you ever been told that you had trouble with your heart?** ☐ Yes ☐ No

13200 IF YES, WAS IT
1. ☐ HEART MURMUR OR LEAKAGE?
2. ☐ RHEUMATIC FEVER OR HEART INFECTION?
3. ☐ IRREGULAR HEART BEAT?
4. ☐ AN ENLARGED HEART?
5. ☐ A HEART ATTACK?
6. ☐ CORONARY ARTERY DISEASE?
7. ☐ HEART FAILURE?
8. ☐ SOMETHING ELSE?
9. ☐ DON'T KNOW

13300 IF YES, ARE YOU CURRENTLY UNDER A DOCTOR'S CARE FOR YOUR HEART? ☐ Yes ☐ No

13400 **Have you had an electrocardiogram (EKG or heart tracing) within the past year?** ☐ Yes ☐ No

13500 IF YES, WAS IT NORMAL? ☐ Yes ☐ No ☐ Don't Know

13600 **Do you have**
1. ☐ SWELLING OF FEET AND ANKLES DAILY?
2. ☐ LEG CRAMPS AT NIGHT OR WITH WALKING, REGULARLY?
3. ☐ VARICOSE VEINS THAT CAUSE YOU TROUBLE?
4. ☐ PHLEBITIS (WITHIN THE PAST YEAR)?
5. ☐ OTHER HEART OR CIRCULATORY TROUBLE?
6. ☐ NONE OF THESE?

13700 **Is your appetite as good as it was a year ago?** ☐ Yes ☐ No → 13750 **Is it better?** ☐ Yes ☐ No

13800 **In the past year, have you had a problem with nausea ("sick to stomach") or vomiting — a real problem, not just having it once in a while?** ☐ Yes ☐ No

13900 IF YES, IS IT
1. ☐ JUST WITH EATING?
2. ☐ ASSOCIATED WITH PAIN OR HEARTBURN?
3. ☐ ASSOCIATED WITH DIZZINESS?
4. ☐ NOT CONNECTED WITH ANYTHING YOU KNOW OF?
5. ☐ GETTING WORSE?
6. ☐ NONE OF THESE?

EMPLOYEE HEALTH TESTING

Identification Number _____

14000 **Do you frequently — once a week or more — have stomach or abdominal distress (heartburn, sour stomach, indigestion, "gas" or pain)?** ☐ Yes ☐ No

14100 IF YES, IS IT
1. ☐ IMMEDIATELY AFTER EATING?
2. ☐ OR WHEN YOUR STOMACH IS EMPTY?
3. ☐ JUST WITH CERTAIN FOODS?
4. ☐ JUST WHEN NERVOUS OR TENSE?
5. ☐ PRETTY MUCH EVERY DAY?
6. ☐ NOT CONNECTED WITH ANY OF THESE?

14200 IS IT
1. ☐ MOSTLY UPPER ABDOMEN?
2. ☐ AROUND THE BELLY BUTTON?
3. ☐ LOWER ABDOMEN?
4. ☐ ALL OVER THE ABDOMEN?
5. ☐ NO PARTICULAR LOCATION?

14300 WHEN YOU GET IT, WHAT RELIEVES IT
1. ☐ ANTACIDS (TUMS, ROLAIDS, SODA, ETC.)?
2. ☐ MILK OR EATING?
3. ☐ BOWEL MOVEMENT OR PASSING GAS?
4. ☐ BELCHING?
5. ☐ VOMITING?
6. ☐ NOTHING HELPS?

14400 HAVE YOU SEEN A DOCTOR FOR THIS PROBLEM? ☐ Yes ☐ No

14500 ARE YOU UNDER PHYSICIAN TREATMENT NOW? ☐ Yes ☐ No

14600 **Have you ever had**
1. ☐ JAUNDICE?
2. ☐ HEPATITIS?
3. ☐ GALL STONES?
4. ☐ ENLARGED LIVER?
5. ☐ ENLARGED SPLEEN?
6. ☐ OTHER LIVER TROUBLE?
7. ☐ NONE OF THESE?

14700 IF YOU HAVE HAD ANY OF THESE PROBLEMS, ARE YOU HAVING TROUBLE WITH THEM NOW? ☐ Yes ☐ No

14800 **Have your bowel movements been normal for you during the past year?** ☐ Yes ☐ No

14900 IF NO, HAS THE PROBLEM BEEN WITH
1. ☐ DIARRHEA (LOOSE, WATERY STOOLS)?
2. ☐ CONSTIPATION (HARD, DRY BOWEL MOVEMENTS)?
3. ☐ SOME OF BOTH?
4. ☐ BRIGHT RED BLOOD IN YOUR STOOLS?
5. ☐ TARRY OR BLACK STOOLS?
6. ☐ THIN, NARROW BMS?
7. ☐ ASSOCIATED PAIN OR CRAMPING?
8. ☐ WHITE, GRAY OR CLAY COLORED STOOLS?
9. ☐ SOMETHING ELSE?

EMPLOYEE HEALTH TESTING

Identification Number

15100 **Have you had recent (past year) problems with**

1. ☐ HEMORRHOIDS OR PILES?
2. ☐ RECTAL FISSURES OR FISTULA?
3. ☐ RECTAL POLYP?
4. ☐ ANAL ITCHING OR BURNING?
5. ☐ RECTAL BLEEDING?
6. ☐ NONE OF THESE?

15200 **Do you have any stomach or intestinal problem that you have not been asked about?** ☐ Yes ☐ No

15300 **Do you have a hernia or rupture?** ☐ Yes ☐ No

15400 IF YES, HAS IT

1. ☐ REQUIRED A TRUSS?
2. ☐ BOTHERED YOU IN YOUR WORK?
3. ☐ BEEN OPERATED ON?
4. ☐ BEEN OPERATED ON AND CAME BACK?
5. ☐ BEEN REOPERATED?
6. ☐ INVOLVED MORE THAN ONE SIDE?
7. ☐ NONE OF THESE?

15500 **Have you noticed any recent change in your urine, or have you had any trouble in starting or passing your urine?** ☐ Yes ☐ No

15600 IF YES, IS IT

1. ☐ PAIN OR BURNING WITH PASSING URINE?
2. ☐ LOSING CONTROL OF THE URINE (DRIBBLING, ETC.)?
3. ☐ TROUBLE WITH STARTING THE STREAM?
4. ☐ SMALL OR WEAK STREAM?
5. ☐ GETTING UP OFTEN AT NIGHT TO URINATE?
6. ☐ BLADDER DOESN'T EMPTY COMPLETELY?
7. ☐ URINE LOOKS BLOODY OR LIKE COCA COLA OR COFFEE?
8. ☐ MUCH MORE FREQUENT URINATION?
9. ☐ NONE OF THESE?

15700 **Have you had a severe kidney problem for which dialysis (artificial kidney) or kidney transplant has been done or recommended?** ☐ Yes ☐ No

15800 **Have you ever had venereal disease (syphilis, gonorrhea, etc.)?** ☐ Yes ☐ No

15900 **Have you had frequent kidney or bladder infections?** ☐ Yes ☐ No

16000 IF YES, ARE YOU HAVING DIFFICULTY NOW? ☐ Yes ☐ No

16100 **Have you ever had kidney or bladder stones?** ☐ Yes ☐ No

16200 **Do you have any disturbing problems in your sexual interests or performance?** ☐ Yes ☐ No

EMPLOYEE HEALTH TESTING

Identification Number

16300 In the past year have you had severe joint pain, stiffness or swelling? ☐ Yes ☐ No

16400 IF YES, WAS IT BEEN
1. ☐ BECAUSE OF SOME INJURY?
2. ☐ CALLED ARTHRITIS BY A DOCTOR?
3. ☐ BOTH OF ABOVE? 07
4. ☐ TREATED WITHIN THE PAST MONTH?
5. ☐ NONE OF THESE?

16500 Do you have back or neck pain that interferes with your usual daily activities? ☐ Yes ☐ No

16600 This year, have you had trouble with
1. ☐ DEFINITE MUSCULAR WASTING?
2. ☐ SEVERE MUSCLE WEAKNESS?
3. ☐ PERSISTENT MUSCLE SWELLING OR SORENESS?
4. ☐ ANY SPECIFIC MUSCULAR DISEASE (MUSCULAR DYSTROPHY, ETC.)?
5. ☐ NONE OF THESE?

16700 Have you ever been told that you were anemic? ☐ Yes ☐ No

16800 IF YES, HAVE YOU
1. ☐ HAD TREATMENT WHICH CORRECTED IT?
2. ☐ BEEN UNDER TREATMENT IN THE LAST 3 MONTHS?
3. ☐ HAD SOME OTHER ILLNESS WHICH CAUSED ANEMIA?
4. ☐ A FAMILY OR INHERITED ANEMIA PROBLEM?
5. ☐ NONE OF THESE?

16900 Have you had
1. ☐ UNUSUAL BLEEDING OR BRUISING?
2. ☐ PERSISTENT SWOLLEN GLANDS IN NECK, ARM PITS OR GROIN?
3. ☐ A FAMILY OR INHERITED PROBLEM WITH BLOOD DISEASE?
4. ☐ PROBLEM WITH TOO MUCH BLOOD (POLYCYTHEMIA)?
5. ☐ A MOLE WHICH HAS RECENTLY CHANGED IN SIZE OR COLOR?
6. ☐ NONE OF THESE?

17000 Do you have any problems with skin eruptions or irritations (rash, etc.)? ☐ Yes ☐ No

17100 IF YES, DOES THIS SEEM TO BE AGGRAVATED BY YOUR WORK? ☐ Yes ☐ No

17200 Has there been any change in the way your hair or fingernails grow? ☐ Yes ☐ No

17300 Do you have severe headaches more than once each week? ☐ Yes ☐ No

17400 IF YES, FOR HOW LONG 1. ☐ Under 3 Mos. 2. ☐ 3-6 Mos. 3. ☐ 6-12 Mos. 4. ☐ Over 1 Yr.

17500 IS YOUR HEADACHE
1. ☐ USUALLY AN EARLY MORNING HEADACHE?
2. ☐ LATE AFTERNOON OR EVENING?
3. ☐ USUALLY LATE AT NIGHT?
4. ☐ CONSTANT?
5. ☐ NO TIME PATTERN?
6. ☐ GETTING WORSE?

EMPLOYEE HEALTH TESTING

Identification Number

17600 **Have you in the past year, had**

1. ☐ DIZZY SPELLS?
2. ☐ PARALYSIS OF ARMS OR LEGS?
3. ☐ SLURRING OF SPEECH?
4. ☐ FAINTING SPELLS?
5. ☐ NUMBNESS OR TINGLING?
6. ☐ TREMORS OR SHAKING?
7. ☐ UNSTEADY WALK OR CLUMSINESS?
8. ☐ BOTHERSOME MEMORY LOSS?
9. ☐ NONE OF THESE?

17700 **Have you in the past year, had**

1. ☐ FITS, CONVULSIONS OR SEIZURES?
2. ☐ SERIOUS HEAD INJURY (UNCONCIOUS)?
3. ☐ A STROKE?
4. ☐ UNUSUAL DROWSINESS OR CONFUSION?
5. ☐ NONE OF THESE?

For women only

18000 **Has your mother or a sister had breast cancer?** ☐ Yes ☐ No

18100 **Do you examine your breasts each month?** ☐ Yes ☐ No

18200 **Have you recently noticed**

1. ☐ A LUMP IN YOUR BREAST?
2. ☐ A DISCHARGE FROM YOUR NIPPLE?
3. ☐ NEITHER?

18300 IF EITHER, HAVE YOU CONSULTED A PHYSICIAN? ☐ Yes ☐ No

18400 **Are your menstrual periods now normal?** ☐ Yes ☐ No

18500 **Are you pregnant now?** ☐ Yes ☐ No

18600 **Within the past few months have you taken hormones or birth control pills?** ☐ Yes ☐ No

18700 **Are you frequently bothered by**

1. ☐ VAGINAL ITCHING OR DISCHARGE?
2. ☐ SEVERE PELVIC PAIN?
3. ☐ PAINFUL SEXUAL INTERCOURSE?
4. ☐ VAGINAL BLEEDING OTHER THAN MENSTRUATION?
5. ☐ NONE OF THESE?

18800 **Have you had a pap smear within the past year?** ☐ Yes ☐ No

18900 **Have you ever had a pap smear that was reported abnormal?** ☐ Yes ☐ No ☐ Don't Know

For men only

19000 **Have you ever had**

1. ☐ A LUMP IN YOUR BREAST?
2. ☐ BREAST ENLARGEMENT FOR NO APPARENT REASON?
3. ☐ DRAINAGE FROM A NIPPLE?
4. ☐ NONE OF THESE?

19100 **Have you ever had any trouble with your prostate gland?** ☐ Yes ☐ No

OR

19200 IF YES, WAS IT

1. ☐ INFECTION?
2. ☐ ENLARGEMENT?
3. ☐ TUMOR?
4. ☐ DON'T KNOW?
5. ☐ NONE OF THESE?

19300 IS IT CAUSING YOU TROUBLE NOW? ☐ Yes ☐ No

19400 **Have you had**

1. ☐ ENLARGEMENT OF ONE TESTICLE?
2. ☐ ABSENCE OF ONE TESTICLE?
3. ☐ STONY HARD LUMP IN THE SCROTUM OR BAG?
4. ☐ DISCHARGE FROM THE PENIS?
5. ☐ PERSISTENT SORE OF THE PENIS?
6. ☐ 'JOCK ITCH'?
7. ☐ SERIOUS AND PERSISTENT PROBLEM GETTING AN ERECTION?
8. ☐ NONE OF THESE?

19500 **Within the last year have you taken**

1. ☐ MALE HORMONES?
2. ☐ FEMALE HORMONES?
3. ☐ 'MUSCLE BUILDING' HORMONES?
4. ☐ NONE OF THESE?

20000 Do you consider your overall health to be good? ..... ☐ Yes ☐ No

20100 Are you usually satisfied with the important decisions you have made? ..... ☐ Yes ☐ No

20200 Have you ever received treatment for emotional or mental illness? ..... ☐ Yes ☐ No

20300 Do you have problems now which you feel would benefit from counselling or guidance? ..... ☐ Yes ☐ No

20400 Do you think you are depressed more often than most people? ..... ☐ Yes ☐ No

20500 In general, do you think most things in your life are getting better? ..... ☐ Yes ☐ No

20600 Do you have problems that concern you that have not been covered? ..... ☐ Yes ☐ No

You have completed the questions. Thank you for your help. Please sign below.

I have read carefully the questions about my medical background on the preceding pages.

I have answered them as accurately as I can.

_____ Signature

Please fill in the identifying information below. Only the medical department will be able to connect you with the information you have provided. Please PRINT.

TODAY'S DATE ____ ____ ____
Mo Day Yr

SOC SEC NO._____ PLANT NO _____
(Clock Card)

NAME _____
First Middle initial Last

ADDRESS _____
Street Number City

_____
State Zip code Phone

BIRTHDATE ____ ____ ____ AGE_____ SEX_____ STATE OF BIRTH_____
Mo Day Yr (If not in U.S.A. — Country of Birth)

JOB TITLE _____

FAMILY DOCTOR. NAME _____

ADDRESS _____

THANK YOU!

JSC

PATIENT HISTORY & HEALTH QUESTIONNAIRE (REVISIT)

NAME	SOCIAL SECURITY #	DATE
HOME ADDRESS	TELEPHONE EXT.	DATE OF PREVIOUS HISTORY

FAMILY HISTORY UPDATE: Have any members of your family had the following? if so please circle

Cancer Diabetes Tuberculosis Stroke Epilepsy
Arthritis Nervous Problems Allergies Heart Disease

Other Serious Conditions: _____

CURRENT HEALTH STATUS OF FAMILY MEMBERS: Please give approximate age, if deceased give cause:

Mother _____ Father _____

Sisters _____ Brothers _____

Spouse _____ Children _____

Number of children _____

PERSONAL HISTORY UPDATE: What has been your general state of health since your last physical?

Excellent _____ Good _____ Fair _____ Poor _____. Have you had any serious illnesses, injuries or operations since your last examination? Yes ____ No ____. If yes, please explain:

_____

_____

Any recent loss or gain of weight? YES _____ NO _____: Number of lbs. _____.

Alcoholic drinks per day: _____. Smoking habits: _____

Exercise: _____

Do you have any of the following complaints? Please Circle Yes or No.

Chronic Cough	Yes	No	Frequent indigestion	Yes	No
Ever cough up blood	Yes	No	Recent change in bowel habits	Yes	No
Lived with anyone having TB	Yes	No	Swollen or painful joints	Yes	No
Blood in stool	Yes	No	Mole or sore not healing	Yes	No
Vomited blood	Yes	No	Swelling, lump or soreness anywhere on body	Yes	No
Swelling ankles	Yes	No			

Comments _____

KSC (also HQ and OFRC)

STANDARD FORM 93
JANUARY 1971
GSA FPMR 101-11.8

Approved
Office of Management and Budget No 29-R0191

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME		2. SOCIAL SECURITY OR IDENTIFICATION NO.
3. HOME ADDRESS *(No. street or RFD, city or town, State, and ZIP CODE)*		4. POSITION *(Title, grade, component)*
5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION	7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS *(Include ZIP Code)*

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint exists)*

9. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
		Lived with anyone who had tuberculosis
		Coughed up blood
		Bled excessively after injury or tooth extraction
		Attempted suicide
		Been a sleepwalker

10. DO YOU *(Please check each item)*

YES	NO	(Check each item)
		Wear glasses or contact lenses
		Have vision in both eyes
		Wear a hearing aid
		Stutter or stammer habitually
		Wear a brace or back support

11. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
			Scarlet fever, erysipelas				Cramps in your legs				"Trick" or locked knee
			Rheumatic fever				Frequent indigestion				Foot trouble
			Swollen or painful joints				Stomach, liver, or intestinal trouble				Neuritis
			Frequent or severe headache				Gall bladder trouble or gallstones				Paralysis (include infantile)
			Dizziness or fainting spells				Jaundice or hepatitis				Epilepsy or fits
			Eye trouble				Adverse reaction to serum, drug				Car, train, sea or air sickness
			Ear, nose, or throat trouble				or medicine				Frequent trouble sleeping
			Hearing loss				Broken bones				Depression or excessive worry
			Chronic or frequent colds				Tumor, growth, cyst, cancer				Loss of memory or amnesia
			Severe tooth or gum trouble				Rupture/hernia				Nervous trouble of any sort
			Sinusitis				Piles or rectal disease				Periods of unconsciousness
			Hay Fever				Frequent or painful urination				
			Head injury				Bed wetting since age 12				
			Skin diseases				Kidney stone or blood in urine				
			Thyroid trouble				Sugar or albumin in urine				
			Tuberculosis				VD—Syphilis, gonorrhea, etc.				
			Asthma				Recent gain or loss of weight				
			Shortness of breath				Arthritis, Rheumatism, or Bursitis				
			Pain or pressure in chest				Bone, joint or other deformity				
			Chronic cough				Lameness				
			Palpitation or pounding heart				Loss of finger or toe	12. FEMALES ONLY: HAVE YOU EVER			
			Heart trouble				Painful or "trick" shoulder or elbow				Been treated for a female disorder
			High or low blood pressure				Recurrent back pain				Had a change in menstrual pattern

13. WHAT IS YOUR USUAL OCCUPATION?

14. ARE YOU *(Check one)*

☐ Right handed ☐ Left handed

93-101

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
		15. Have you been refused employment or 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 assume certain positions.
		D. Other medical reasons (*If yes, give reasons.*)
		16. Have you ever been treated for a mental condition? (*If yes, specify when, where, and give details.*)
		17. Have you ever been denied life insurance? (*If yes, state reason and give details.*)
		18. Have you had, or have you been advised to have, any operations? (*If yes, describe and give age at which occurred.*)
		19. Have you ever been a patient in any type of hospitals? (*If yes, specify when, where, why, and name of doctor and complete address of hospital.*)
		20. Have you ever had any illness or injury other than those already noted? (*If yes, specify when, where, and give details.*)
		21. 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, clinic, and details.*)
		22. Have you ever been rejected for military service because of physical, mental, or other reasons? (*If yes, give date and reason for rejection.*)
		23. Have you ever been discharged from military service because of physical, mental, or other reasons? (*If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.*)
		24. 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.*)

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 authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

25. Physician's summary and elaboration of all pertinent data (*Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.*)

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS

REVERSE OF STANDARD FORM 93

GPO : 1971 O - 419-371

Medical Examination Input

C-5FC

Standard Form 88
Revised April 1968
General Services Administration
Interagency Comm. on Medical Records
FPMR 101-11.806-8

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
4. HOME ADDRESS (*Number, street or RFD, city or town, State and ZIP Code*)	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS		16. OTHER INFORMATION
17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (*Total*)	LAST SIX MONTHS

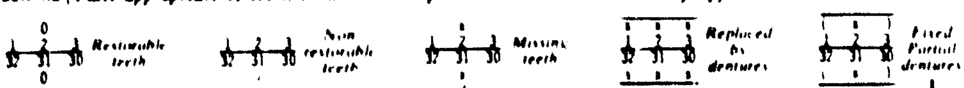
CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNORMAL
	18. HEAD, FACE, NECK, AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS—GENERAL (*Int. & ext. canals*) (*Auditory acuity under items 70 and 71*)	
	23. DRUMS (*Perforation*)	
	24. EYES—GENERAL (*Visual acuity and refraction under items 59, 60 and 67*)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (*Equality and reaction*)	
	27. OCULAR MOTILITY (*Associated parallel movements, nystagmus*)	
	28. LUNGS AND CHEST (*Include breasts*)	
	29. HEART (*Thrust, size, rhythm, sounds*)	
	30. VASCULAR SYSTEM (*Varicosities, etc.*)	
	31. ABDOMEN AND VISCERA (*Include hernia*)	
	32. ANUS AND RECTUM (*Hemorrhoids, fistulae*) (*Prostate, if indicated*)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (*Strength, range of motion*)	
	36. FEET	
	37. LOWER EXTREMITIES (*Except feet*) (*Strength, range of motion*)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC (*Equilibrium tests under item 72*)	
	42. PSYCHIATRIC (*Specify any personality deviation*)	
	43. PELVIC (*Females only*) (*Check how done*) ☐ VAGINAL ☐ RECTAL	

NOTES (*Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.*)

(Continue in item 73)

44. DENTAL (*Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.*)



R I G H T	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L E F T
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY		46. CHEST X-RAY (*Place, date, film number and result*)
B. ALBUMIN	D. MICROSCOPIC	
C. SUGAR		

47. SEROLOGY (*Specify test used and result*)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS

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MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD ☐ SLENDER ☐ MEDIUM ☐ HEAVY ☐ OBESE	56 TEMPERATURE

57. BLOOD PRESSURE (*Arm at heart level*)						58. PULSE (*Arm at heart level*)				
A SITTING	SYS / DIAS	B RECUMBENT	SYS / DIAS	C STANDING (1 min.)	SYS / DIAS	A SITTING	B AFTER EXERCISE	C 2 MIN AFTER	D RECUMBENT	E AFTER STANDING 1 MIN

59. DISTANT VISION		60 REFRACTION			61. NEAR VISION	
RIGHT 20/	CORR TO 20/	BY	S.	CX	CORR TO	BY
LEFT 20/	CORR TO 20/	BY	S	CX	CORR TO	BY

62. HETEROPHORIA (*Specify distance*)

ES° EX° R H L H PRISM DIV PRISM CONV. CT PC PD

63. ACCOMMODATION		64. COLOR VISION (*Test used and result*)	65. DEPTH PERCEPTION (*Test used and score*)	UNCORRECTED
RIGHT	LEFT			CORRECTED
66. FIELD OF VISION		67. NIGHT VISION (*Test used and score*)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING			71. AUDIOMETER									72. PSYCHOLOGICAL AND PSYCHOMOTOR (*Tests used and score*)
RIGHT WV	/15 SV	/15		250 Cps	500 512	1000 1024	2000 2048	3000 3072	4000 4096	6000 6144	8000 8192	
LEFT WV	/15 SV	/15	RIGHT									
			LEFT									

73. NOTES (*Continued*) AND SIGNIFICANT OR INTERVAL HISTORY

(*Use additional sheets if necessary*)

74. SUMMARY OF DEFECTS AND DIAGNOSES (*List diagnoses with item numbers*)

75. RECOMMENDATIONS FURTHER SPECIALIST EXAMINATIONS INDICATED (*Specify*)	76. A PHYSICAL PROFILE					
	P	U	L	H	E	S

77. EXAMINEE (*Check*)	B PHYSICAL CATEGORY
A ☐ IS QUALIFIED FOR B ☐ IS NOT QUALIFIED FOR	

78. IF NOT QUALIFIED LIST DISQUALIFYING DEFECTS BY ITEM NUMBER	A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE	
80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE	
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (*Indicate which*)	SIGNATURE	
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE	NUMBER OF ATTACHED SHEETS

GSFC

GODDARD SPACE FLIGHT CENTER

OCCUPATIONAL MEDICINE PROGRAM EXAMINATION SUMMARY

NAME (LAST - FIRST - MIDDLE)	GRADE	EXAMINATION TYPE	DATE OF EXAMINATION

ADDRESS (INCLUDING ZIP CODE)

EXAMINATION DATA (N = NORMAL; SR = SEE REMARKS)

AGE	SEX	HEIGHT	WEIGHT	TEMPERATURE	BLOOD PRESSURE POSITION	SYS.	DIAS	PULSE	SIGMOIDOSCOPY	RECTAL	PELVIC	ECG	VISUAL TESTING	AUDIO TESTING	TONOMETRY S.B. DISC. (NORMAL 18-24) INITIAL		REPEAT	
	M				SITTING				N	N	N	N	N	N	O.D		O.D	
	F				RECUMB.				SR	SR	SR	SR	SR	SR	O.S		O.S	

HEMATOLOGY			CHEMISTRIES			URINE			X-RAYS	N	SR
HGB			BLOOD SUGAR	80-120 MG%		SP. GR. 1.0			CHEST		
RBC			CHOLESTEROL	150-250 MG%		PH			GASTRO INTESTINAL		
HCT %			UREA NITROGEN	8-25 MG%		ALBUMIN			BARIUM ENEMA		
DIFFERENTIAL WBC			URIC ACID	2-8 MG%		GLUCOSE			GALL BLADDER		
DIFFERENTIAL PMN			P.B.I.	3-8 MCG%		MICRO ACETONE			LUMBO SARCAL SP		
DIFFERENTIAL BANDS			CEPH FLOC 24 HR.	0 UNITS		MICRO RBC PER HPF			CERVICAL SP		
DIFFERENTIAL LYMPH			CEPH FLOC 48 HR.	1+ UNITS		MICRO WBC PER HPF			SKULL		
DIFFERENTIAL MONO			THYMOL T	1-4 UNITS		MICRO EPITH.			I.V. PYELOGRAM		
DIFFERENTIAL EOS			BILIRUBIN DIRECT	NEG.		MICRO CASTS			OTHER TESTS	N	SR
DIFFERENTIAL BASO			BILIRUBIN INDIRECT	0.2-0.8 MG%		MICRO CRYSTALS			PHEMO		
ESR MM/HR			ALK. PHOS	2-8 BOD UNITS		MICRO CLUMPS			SMOKES		
BLOOD TYPE			ALBUMIN	4.0-5.0 GMS%					CRP		
R.H FACTOR			GLOBULIN	2.0-2.5 GMS%					FEV		
SEROLOGY			Triglyceride			PAP. SMEAR N SR			Stool occult blood		

REMARKS (SIGNIFICANT HISTORY, PHYSICAL, CONCLUSIONS AND RECOMMENDATIONS)

SIGNATURE OF EXAMINER

CLEVELAND CLINIC

EXECUTIVE HEALTH EVALUATION DATA

SEX	DATE OF BIRTH
OCCUPATION	

	DATE								
	AGE								
	HEIGHT								
	WEIGHT								
	BLOOD PRESSURE RT.								
	BLOOD PRESSURE LT.								
	ANTIHYPERTENSIVE MED.								
	BLOOD PRESSURE STAND.								
VISION	FAR RIGHT								
	FAR LEFT								
	FAR BOTH								
	NEAR RIGHT								
	NEAR LEFT								
	NEAR BOTH								
	TONOMETRY DEVICE								
	TONOMETRY RIGHT								
	TONOMETRY LEFT								
AUDIOGRAM	LOSS RIGHT 500								
	LOSS RIGHT 1000								
	LOSS RIGHT 2000								
	LOSS RIGHT 3000								
	LOSS RIGHT 4000								
	LOSS RIGHT 6000								
	LOSS LEFT 500								
	LOSS LEFT 1000								
	LOSS LEFT 2000								
	LOSS LEFT 3000								
	LOSS LEFT 4000								
	LOSS LEFT 6000								
SPIROMETRY	VC obs./pred.								
	FVC "								
	FEV_1 "								
	FEV_1/FVC								
	$FEF_{25-75\%}$ "								
	PEF "								

F 916 4/80

BLOOD COUNT	WBC COUNT								
	RBC COUNT								
	HEMOGLOBIN								
	HEMATOCRIT								
	MCV								
	MCH								
	MCHC								
	PLATELETS								
BLOOD BIOCHEMISTRY PROFILE	CALCIUM								
	PHOSPHORUS								
	GLUCOSE								
	BUN								
	URIC ACID								
	CHOLESTEROL								
	TOTAL PROTEIN								
	ALBUMIN								
	TOTAL BILIRUBIN								
	ALK. PHOSPHATASE								
	LDH								
	SGOT								
	TRIGLYCERIDES								
URINE ANALYSIS	pH								
	SPECIFIC GRAVITY								
	PROTEIN								
	GLUCOSE								
	RBC'S								
	WBC'S								
	CASTS								
OTHER	STOOL OCCULT BLOOD								

Diamond Shamrock
Diamond Shamrock Health Systems, Inc.
1100 Superior Avenue
Cleveland, Ohio 44114
Phone: 216 694-6242

Monitrac[SM] Laboratory Test Findings

NAME 0072345 Age= 44 Sex=M

3/09 4:00pm					
Blood	CBC COULTER				
	WBC	7.3		thou ccm	(4.5-11.0)
	RBC	4.70		mil/ccm	(4.50-6.00)
	Hgb	13.4	L	gm/dl	(14.0-18.0)
	Hct	38.0	L	%	(40.0-54.0)
	MCV	87		cu micron	(82-92)
	MCH	29.0		uuo	(27.0-31.0)
	MCHC	34.0		%	(32.0-36.0)
3/09 4:00pm					
Serum	SMAC PROFILE				
	Glucose	260	H	mg/dl	(65-115)
	Bun	12		mg/dl	(7-26)
	Creatinine	1.1		mg/dl	(.4-1.5)
	Sodium	139		meq/L	(135-147)
	Potassium	4.8		meq/L	(3.5-5.5)
	Chloride	102		meq/L	(97-108)
	CO2	28		meq/L	(22-33)
	Uric Acid	5.2		mg/dl	(4.0-8.5)
	Calcium	10.2		mg/dl	(8.2-10.5)
	Phosphorus	3.8		mg/dl	(2.5-4.5)
	BUN / CREAT	11.00			(7.00-28.00)
	Lyte balance	12		meq/L	(0-16)
	Cholesterol	365	H	mg/dl	(150-300)
	Triglyceride	110		mg/dl	(30-200)
	Total Prot	7.8		g/dl	(6.0-8.0)
	Albumin	4.4		g/dl	(3.5-5.0)
	Tot Bili	.9		mg/dl	(.2-1.2)
	Alk P:tase	56		U/L	(30-115)
	SGOT (AST)	38		U/L	(7-40)
	LDH	160		U/L	(100-225)
	GGT	31		U/L	(8-37)
	SGPT	25		U/L	(7-40)
	Globulin	2.2		g/dl	(2.0-3.5)
	AG Ratio	2.0			(1.0-2.5)
3/09 4:00pm					
Urine	URINALYSIS				
	Color	STRAW			
	Appearance	CLEAR			
	Spec Grav	1.020			
	pH	6.0			
	Protein	NEG			
	Glucose	2+			
	Ketones	1+			
	Occult Blood	NEG			
	Bile	NEG			
	Micro Neg	NEG			

UNMARKED - NO SIGNIFICANCE
1 - BORDERLINE
2 - STATISTICALLY SIGNIFICANT
3 - ABNORMAL SIGNIFICANCE
4 - SUGGEST RECHECK

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216-694-6242

nitrac℠ Measurements/Physician Examination

Height ___ ___.___ In.
Weight ___ ___ ___ Lbs
B.P. Sys ___ ___ ___ MM
Dias ___ ___ ___ MM
Pulse ___ ___ ___ /Min

PFR ___.___ ___ L/Min.
FVC ___.___ ___ L
FEV-1 ___.___ ___ L
FEV_3/FVC ___ ___ %

1☐ No Glasses 2☐ Glasses/Contacts 3☐ Glasses - Near Only 4☐ Glasses - Far Only
Left Both Right

Far ___ ___ ___ ___ ___ ___ ___ ___ ___ Phoria-V ___ Lat ___
Near ___ ___ ___ ___ ___ ___ ___ ___ ___ Color ___ Depth P. ___

TONOMETRY
Right ___ ___ Left ___ ___

Comments

A MUSCULOSKELETAL
2 ☐ Erect posture abnormal
3 ☐ Gait abnormal
4 ☐ Other abnormality*

EYES
5 ☐ Pupils unequal
6 ☐ Pupils abn. react to light
7 ☐ Pupils abn. accomodation
8-9 ☐☐ Sclera/conjunct. jaundice
10-11 ☐☐ Sclera/conjunct. hemorrhage
12-13 ☐☐ Sclera/conjunct. injected
14-15 ☐☐ Eyelid irritated
16-17 ☐☐ Ocular muscle abnormal
18-19 ☐☐ Fundi-papilledema
20-21 ☐☐ Fundi-A/V nicking
22-23 ☐☐ Fundi hemorrhage
24-25 ☐☐ Fundi exudate
26 ☐ Other abnormality*

EARS
27-28 ☐☐ Excess wax
29-30 ☐☐ External otitis
31-32 ☐☐ Drum perforation
33-34 ☐☐ Drum Scar
35-36 ☐☐ Drum Inflammation
37 ☐ Other abnormality*

NOSE/SINUS
38 ☐ Septum deviation
39 ☐ Mucosa injected
40 ☐ Nasal polyps
41 ☐ Other abnormality*

MOUTH/THROAT
42 ☐ Dental caries
43 ☐ Tongue abnormal
44 ☐ Gingiva abnormal
45 ☐ Pharynx abnormal
46 ☐ Hoarseness
47 ☐ Other abnormality*

B THYROID/NECK
1-2 ☐☐ Enlarged lymph glands
3-4 ☐☐ Thyroid nodules
5 ☐ Thyroid enlarged
6 ☐ Other abnormality*

BREASTS
7-8 ☐☐ Nipple abnormal
9-10 ☐☐ Cysts palpable
11-12 ☐☐ Nodules palpable
13-14 ☐☐ Axillary gland enlarged
15 ☐ Other abnormality*
16 ☐ Refused exam

LUNGS/THORAX
17-18 ☐☐ Rales
19-20 ☐☐ Rhonchi
21 ☐ Wheezing
22 ☐ Other abnormality*

HEART
23 ☐ Apical shift
24 ☐ Murmur
25 ☐ Other abnormality*

ABDOMEN
26 ☐ Liver enlarged
27 ☐ Spleen enlarged
28 ☐ Significantly tender
29 ☐ Obese
30 ☐ Other abnormality*

HERNIA
31-32 ☐☐ Inguinal hernia
33-34 ☐☐ Femoral hernia
35 ☐ Other abnormality*

EXTERNAL GENITALIA
36-37 ☐☐ Testicular mass
38-39 ☐☐ Varicocele
40-41 ☐☐ Hydrocele
42 ☐ Other abnormality*
43 ☐ Refused exam

C RECTAL
1 ☐ Fissure present
2 ☐ Hemorrhoids
3 ☐ Rectal mass
4 ☐ Prostate abnormal
5 ☐ Other abnormlity*
6 ☐ Refused exam

PELVIC
7 ☐ Cervix erosion
8 ☐ Uterus enlarged
9 ☐ Adnexa abnormal
10 ☐ Other abnormality*
11 ☐ Refused exam

SPINE/BACK
12 ☐ Motion limited
13 ☐ Tenderness
14 ☐ Lordosis
15 ☐ Scoliosis
16 ☐ Other abnormality*

EXTREMITIES
17-18 ☐☐ Limited motion
19-20 ☐☐ Joint tenderness
21-22 ☐☐ Joint swelling
23-24 ☐☐ Feet pes planus
25-26 ☐☐ Edema
27-28 ☐☐ Significant varicosities
29 ☐ Other abnormlity*

SKIN
30 ☐ Abn. pigmented skin lesion
31 ☐ Spider nevi
32 ☐ Dermatitis
33 ☐ Other abnormality*

NEUROLOGICAL
34 ☐ Abn. alternating hand motion
35 ☐ Abn. standing/eyes closed
36 ☐ Reflex abnormal
37 ☐ Other abnormality*

* Other abnormalities:

D 3443-28

All of the above systems were examined and found to be within normal limits except for the findings noted

_____, M.D.

Diamond Shamrock
Diamond Shamrock Health Systems, Inc.
1100 Superior Avenue
Cleveland, Ohio 44114
Phone 216 694-6242

[redacted]

itrac[SM] **Chest X-Ray Findings**

PA VIEW ☐
LATERAL VIEW ☐ L ☐ R

D 3457-3

1	☐ WITHIN NORMAL LIMITS	15	☐ HILAR CALCIFIED PROB BENIGN LESION(S) (R)
2	☐ EMPHYSEMA	16	☐ HILAR CALCIFIED PROB BENIGN LESION(S) (L)
3	☐ ABNORMALITY OF SOFT TISSUES	17	☐ SUSPICIOUS DENSITY OR LESION(S) (R)
4	☐ ABNORMALITY OF BONY STRUCTURES	18	☐ SUSPICIOUS DENSITY OR LESION(S) (L)
5	☐ ELEVATED DIAPHRAGM (R)	19	☐ PULMONARY INFILTRATE (R)
6	☐ ELEVATED DIAPHRAGM (L)	20	☐ PULMONARY INFILTRATE (L)
		21	☐ CALCIFICATIONS OF THE AORTA
		22	☐ TORTUOUS AORTA
7	☐ BLUNTED COSTO-PHRENIC ANGLE (R)	23	☐ CARDIAC ENLARGEMENT
8	☐ BLUNTED COSTO-PHRENIC ANGLE (L)		
9	☐ PLEURAL THICKENING AND/OR FLUID (R)	24	☐ RECOMMEND REPEAT LATERAL (R)
10	☐ PLEURAL THICKENING AND/OR FLUID (L)	25	☐ RECOMMEND REPEAT LATERAL (L)
11	☐ PULMONARY ARTERIES ENLARGEMENT (R)	26	☐ RECOMMEND REPEAT PA
12	☐ PULMONARY ARTERIES ENLARGEMENT (L)	27	☐ COMPARE WITH PREVIOUS FILMS
13	☐ PULMONARY FIBROSIS	28	☐ PROCESSING ARTIFACTS
14	☐ DIFFUSE PULMONARY CALCIFICATIONS	29	☐ FILM QUALITY UNACCEPTABLE

Film Interpreted By _____ M D

Diamond Shamrock
Diamond Shamrock Health Systems, Inc.
1100 Superior Avenue
Cleveland, Ohio 44114
Phone. 216 694-6242

72345

[redacted]

nitrac[SM] Electrocardiogram Findings

D 3447-2

1 ☐ UNSATISFACTORY TEST
2 ☐ WITHIN NORMAL LIMITS
3 ☐ BORDERLINE
4 ☐ NON-SPECIFIC ABNORMALITY
5 ☐ ABNORMAL ECG

6 ☐ LEFT AXIS DEVIATION
7 ☐ RIGHT AXIS DEVIATION
8 ☐ SINUS BRADYCARDIA
9 ☐ SINUS TACHYCARDIA
10 ☐ ATRIAL FIBRILLATION
11 ☐ ATRIAL FLUTTER

12 ☐ PREMATURE BEATS (SUPRAVENTRICULAR)
13 ☐ PREMATURE BEATS (VENTRICULAR)
14. ☐ A—V BLOCK (1st DEGREE)
15. ☐ A—V BLOCK (2nd DEGREE)
16. ☐ A—V BLOCK (3rd DEGREE)

17. ☐ I-V CONDUCTION DELAY (LEFT MILD)
18. ☐ I-V CONDUCTION DELAY (RIGHT MILD)
19. ☐ COMPLETE LEFT BUNDLE BRANCH BLOCK
20 ☐ COMPLETE RIGHT BUNDLE BRANCH BLOCK
21 ☐ LEFT ANTERIOR HEMIBLOCK

22 ☐ RIGHT VENTRICULAR HYPERTROPHY
23 ☐ LEFT VENTRICULAR HYPERTROPHY
24 ☐ LEFT VENTRICULAR HYPERTROPHY AND STRAIN
25 ☐ RIGHT ATRIAL ABNORMALITIES
26 ☐ LEFT ATRIAL ABNORMALITIES

27 ☐ SHORT P R INTERVAL
28 ☐ WOLF — PARK — WHITE
29 ☐ MYOCARDIAL INFARCTION (ANT.WALL)
30 ☐ MYOCARDIAL INFARCTION (INF. WALL)
31 ☐ ST–T VARIATION

32 ☐ T—WAVE INVERSION
33 ☐ T—WAVE INVERSION (DIFFUSED)
34 ☐ EARLY REPOLARIZATION
35. ☐ POOR R WAVE PROGRESSION (V LEADS)
36. ☐ CLOCKWISE ROTATION
37. ☐ COUNTER-CLOCKWISE ROTATION

_____
_____
_____
_____
_____
_____

Tracing Interpreted By [redacted] M.D.

Health Profiles (Output)

NAME: [redacted] AGE: 27 DATE: 08/29/77
SRN: [redacted] ID: [redacted]

SOCIAL HX

MARITAL STATUS: MARRIED (FIRST MARRIAGE) SEX: MALE
U.S. CITIZEN BY BIRTH
EDUCATION: SOME COLLEGE

FAMILY HX

FATHER : STILL LIVING
MOTHER: STILL LIVING
PATERNAL GRANDFATHER: DIED BETWEEN AGES OF 70-79
PATERNAL GRANDMOTHER: STILL LIVING
MATERNAL GRANDFATHER: DIED BETWEEN AGES OF 60-69
MATERNAL GRANDMOTHER: STILL LIVING
FATHER'S HX: COLOR BLINDNESS, HIGH BLOOD PRESSURE (HYPERTENSION), STOMACH ULCERS
MOTHER'S HX: INDICATES NO HX OF ILLNESS
PATERNAL FAMILY HX: DIABETES, EPILEPSY, STOMACH ULCERS
MATERNAL FAMILY HX: ARTHRITIS OR RHEUMATISM, MIGRAINE HEADACHE, THYROID DISEASE
SIBLING'S HX: INDICATES NO HX OF ILLNESS
CHILDREN'S HX: INDICATES NO HX OF ILLNESS

PATIENT PAST HISTORY

HX OF BROKEN BONES, HX OF CONCUSSION, HX OF HEPATITIS, HX OF SLIPPED DISC, HX OF HX OF ULCER
SURGERY: TONSILS, BONES OR JOINTS

HABITS

DOES NOT SMOKE
HAS NOT PREVIOUSLY SMOKED
DRINKING: DRINKS ONLY SOCIALLY
DRINKING LAST TIME, HAD 1-2 DRINKS
CAN STOP DRINKING AFTER 1-2 DRINKS
DRINKS MAINLY ONLY ON WEEKENDS, HOLIDAYS, DAYS OFF
INTERVAL BETWEEN DRINKING: MORE THAN A MONTH
NEVER HAS DRINKING BLACKOUTS
RECENTLY DRINKING HAS STAYED THE SAME

OCCUPATIONAL HX

INDICATES NO ROUTINE EXPOSURE

DRUG HX

PRESENT MEDICATIONS: INDICATES TAKING NO MEDICATION

ALLERGY HX

ALLERGIC REACTION TO: INDICATES NO ALLERGIC REACTIONS

SYSTEMS REVIEW

HEAD

DENIES CONVULSIONS

EYES

WEARS CONTACT LENSES

ENT

FREQ. HAS TROUBLE WITH BLEEDING GUMS

HAS OWN TEETH

[redacted]

CARDIO-PULMONARY

INDICATES NO HX OF CHEST PAIN
HAS COUGHED UP BLOOD

GASTROINTESTINAL

INDICATES NO PROBLEMS

NEUROMUSCULAR-PSYCHOLOGICAL

HAS DRIVES SELF MOST OF TIME

ENDOCRINE

GAINED MORE THAN 10 POUNDS FOR NO APPARENT REASON

GENITO-URINARY

INDICATES NO PROBLEMS

GENERAL

SOME PHYSICAL ACTIVITY AT WORK, SOME PHYSICAL ACTIVITY AT LEISURE
HEALTH DOES NOT LIMIT WORK

*** PHYSICIAN DICTATION-COMMENTS ***

NAME: [redacted] AGE: 40 DATE: 01/11/80
SSN: [redacted] ZIP: [redacted]

SOCIAL HX

MARITAL STATUS: REMARRIED - July 79 SEX: MALE
U.S. CITIZEN BY BIRTH
EDUCATION: ALL HIGH SCHOOL

FAMILY HX

FATHER : STILL LIVING 64
MOTHER: STILL LIVING 60
PATERNAL GRANDFATHER: DIED BETWEEN AGES OF 50-59
PATERNAL GRANDMOTHER: DIED BETWEEN AGES OF 60-69
MATERNAL GRANDFATHER: DIED BETWEEN AGES OF 70-79
MATERNAL GRANDMOTHER: STILL LIVING 80
FATHER'S HX: ALCOHOLISM, CIRRHOSIS, EMPHYSEMA,
HIGH BLOOD PRESSURE (HYPERTENSION), KIDNEY DISEASE, STOMACH ULCERS
MOTHER'S HX: HIGH BLOOD PRESSURE (HYPERTENSION)
PATERNAL FAMILY HX: ALCOHOLISM
MATERNAL FAMILY HX: CANCER, HEART ATTACK
4 SIBLING'S HX: INDICATES NO HX OF ILLNESS
2 CHILDREN'S HX: INDICATES NO HX OF ILLNESS well.

PATIENT PAST HISTORY

HX OF ABNORMAL ECG (CARDIOGRAM) , HX OF HEART MURMURS, HEART MURMURS WITHIN PAST YEAR
SURGERY: INDICATES NO SURGERY
HAS BEEN OUTSIDE THE CONTINENTAL U.S. OR CANADA

HABITS

DOES NOT SMOKE
HAS NOT PREVIOUSLY SMOKED
DRINKING: DRINKS REGULARLY 2 DRINKS A DAY OR LESS
DRINKING LAST TIME, HAD 1-2 DRINKS
CAN STOP DRINKING AFTER 1-2 DRINKS
DRINKS THROUGHOUT THE WEEK AND ON WEEKENDS 2-3
INTERVAL BETWEEN DRINKING: DRINKS STEADILY beer/nite.
NEVER HAS DRINKING BLACKOUTS
RECENTLY DRINKING HAS DECREASED
HAS DECIDED TO QUIT DRINKING

[redacted] .SEX:M
[redacted] SSN [redacted]
1/11/80 LASL AGE:40

OCCUPATIONAL HX

INDICATES NO ROUTINE EXPOSURE

DRUG HX

PRESENT MEDICATIONS: SLEEPING PILLS

ALLERGY HX

ALLERGIC REACTION TO: INDICATES NO ALLERGIC REACTIONS

SYSTEMS REVIEW

HEAD

DENIES CONVULSIONS
OFTEN HAD MUCH DIFFICULTY FALLING ASLEEP.
HAD MUCH DIFFICULTY STAYING ASLEEP.
AWAKENED EARLY IN THE MORNING AND COULD NOT GO BACK TO SLEEP

EYES

DOES NOT WEAR GLASSES

EAT

HAS OWN TEETH

CARDIO-PULMONARY
INDICATES NO HX OF CHEST PAIN

GASTROINTESTINAL
INDICATES NO PROBLEMS

NEUROMUSCULAR-PSYCHOLOGICAL
INDICATES NO PROBLEMS

ENDOCRINE
INDICATES NO PROBLEMS

[redacted] .SEX:M
[redacted] SSN: [redacted]
1/11/80 LASL AGE:40

GENITO-URINARY
HAS BEEN GETTING UP MORE THAN ONCE A NIGHT TO URINATE when I must sleep for 4-5 years.

GENERAL
HAS WEIGHED AT LEAST 30 LBS. MORE THAN NOW
SOME PHYSICAL ACTIVITY AT WORK. STRENUOUS PHYSICAL ACTIVITY AT LEISURE
HEALTH DOES NOT LIMIT WORK

*** PHYSICIAN DICTATION-COMMENTS *** Jogs 4 mi/day -

NAME: [redacted]
SSN: [redacted]

LASL PERIODIC EXAMINATION

January 22, 1980

SUMMARY

40 year old Electronics Technician, X-7, last examined here a little over three years ago. The only health development of significance was a bad sprain of his right ankle in October, 1976 which required about six months for complete healing. Note that this employee carries a past history of 1) Asymptomatic IV septal defect. 2) Rather marked red-green color vision defect and 3) Moderate impairment of hearing in his right ear.

The employee jogs four miles a day five days a week. Feels splendid in all respects. However, he has been a victim of periodic long standing low grade insomnia for which he has resorted to 60 mgm. DALMANE one or two nights per month for years. Apparently, Dr. Hertzman has prescribed these for him in the past. Whereas, he formerly drank large quantities of beer, he says he now has reduced that intake to two to three beers per night. "Since looking at my father's situation so recently and finding it so depressing".

That father apparently was a very highly productive aggressive mechanical engineer over the years in the East and always felt great pressures at work. He has been a long standing alcoholic and heavy smoker along with peptic ulcers and long standing hypertension. Now he has advanced cirrhosis of the liver, kidney failure, and is on dialysis of some type. He is not expected to live throughout the balance of this year. The 60 year old mother also has hypertension but under good control and is otherwise well. The paternal grandfather was an alcoholic. The paternal grandmother died in her 60's of a heart attack. The maternal grandfather died in her 70's five years ago of a heart attack. The maternal grandmother remains living and well at 80. One sibling is well.

DOES NOT WEAR GLASSES

ENT

WAS CAN TEETH

CARDIO-PULMONARY
INDICATES NO HX OF CHEST PAIN

GASTROINTESTINAL
INDICATES NO PROBLEMS

NEUROMUSCULAR-PSYCHOLOGICAL
INDICATES NO PROBLEMS

ENDOCRINE
INDICATES NO PROBLEMS

[redacted] SEX:M
SSN: [redacted]
1/11/80 LASL AGE:40

GENITO-URINARY
HAS BEEN GETTING UP MORE THAN ONCE A NIGHT TO URINATE when I want to sleep for years.

GENERAL
HAS WEIGHED AT LEAST 30 LBS. MORE THAN NOW
SOME PHYSICAL ACTIVITY AT WORK. STRENUOUS PHYSICAL ACTIVITY AT LEISURE
HEALTH DOES NOT LIMIT WORK

*** PHYSICIAN DICTATION-COMMENTS *** Jogs 4 mi/day -

NAME: [redacted]
SSN: [redacted]

LASL PERIODIC EXAMINATION

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SUMMARY

40 year old Electronics Technician, X-7, last examined here a little over three years ago. The only health development of significance was a bad sprain of his right ankle in October, 1976 which required about six months for complete healing. Note that this employee carries a past history of 1) Asymptomatic IV septal defect. 2) Rather marked red-green color vision defect and 3) Moderate impairment of hearing in his right ear.

The employee jogs four miles a day five days a week. Feels splendid in all respects. However, he has been a victim of periodic long standing low grade insomnia for which he has resorted to 60 mgm. DALMANE one or two nights per month for years. Apparently, Dr. Hertzman has prescribed these for him in the past. Whereas, he formerly drank large quantities of beer, he says he now has reduced that intake to two to three beers per night. "Since looking at my father's situation so recently and finding it so depressing".

That father apparently was a very highly productive aggressive mechanical engineer over the years in the East and always felt great pressures at work. He has been a long standing alcoholic and heavy smoker along with peptic ulcers and long standing hypertension. Now he has advanced cirrhosis of the liver, kidney failure, and is on dialysis of some type. He is not expected to live throughout the balance of this year. The 60 year old mother also has hypertension but under good control and is otherwise well. The paternal grandfather was an alcoholic. The paternal grandmother died in her 60's of a heart attack. The maternal grandfather died in her 70's five years ago of a heart attack. The maternal grandmother remains living and well at 80. One sibling is well.

X-RAY REPORT

NAME: [redacted] AGE=00 DATE: 01/11/00
2[redacted] SSN#[redacted] EMPLOYER:LASL

X-RAY TAKEN: POSTERIOR-ANTERIOR & LATERAL

CLINICAL INDICATIONS: ROUTINE

NO SIGNIFICANT ABNORMALITIES PRESENT. NO INTERVAL CHANGE SINCE LAST EXAM

RADIOLOGIST: [redacted], M.D.

SIGNED:

LASL LABORATORY REPORT
DATE:1/11/80

NAME: [redacted] SEX:M AGE:40
SSN: [redacted] T: [redacted] EMPL:LASL
VISIT:ROUTINE

<HEMOGRAM>

NORMAL	TEST	HI/LO	1/11/80 RESULT
14.0-18.0 GM	HGH:		15.80 GMS
40-50%	HCT:		46%
4.6-6.2 MILLION	RBC:		
5.0-10.0 X 1000	WBC:		5.40 X1000

RED CELL INDICES
32-36 GM/100ML MCHC 34.34

PATIENT ATE 1 HOURS BEFORE DRAWING BLOOD.

DIFFERENTIAL:

50-70%	SEGS:	L	45%
0-5%	BAND:		1%
	METAS:		0%
	MYELO:		0%
20-40%	LYMPHS:	H	52%
	ATYP:		0%
1-6%	MONO:	L	0%
1-5%	EOSIN:		1%
0-1%	BASO:		1%

RBC NORMAL:
PLATELETS: NORMALSED=09
SEROLOGY: NON-REACTIVE

<URINALYSIS>

SPECIFIC GRAVITY: 1.018
COLOR/APPEARANCE: YELLOW, CLEAR

PH:	5	WBC/HPF:	0
PROTEIN:	0	RBC/HPF:	0
GLUCOSE:	0	HYALINE:	0
KETONES:	0	GRANULAR:	0
BILIRUBIN:	NEGATIVE	CELLULAR:	0
OCCULT BLOOD:	NEGATIVE	WAXY:	0

UROBILINOGEN: 0.1

MUCOUS:FEW

<AUDIO>
DATE: 04/05/7M

NAME: [redacted]
SSN: [redacted]

SEX:M

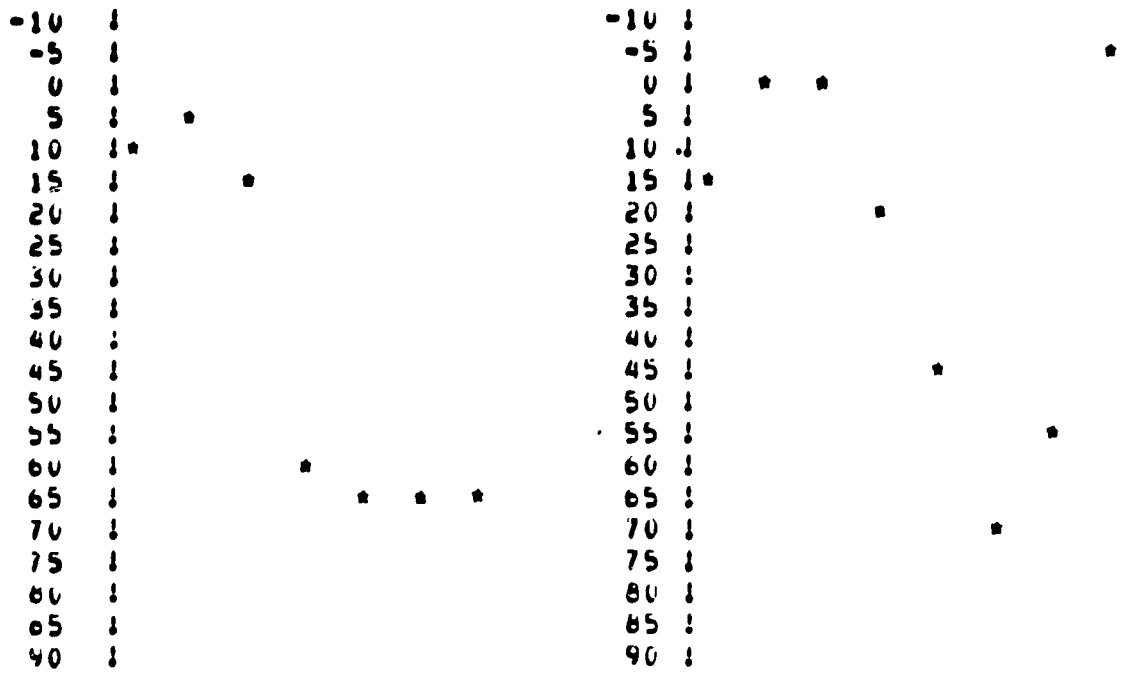
AGE: 47
Z:000111

LEFT

	1	2	3	4	6	8
5	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0

RIGHT

	1	2	3	4	6	8	1
5	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0



<AVG CONVERSATIONAL RANGE LOSS> (500, 1K, 2K HERTZ)

LEFT: 0%
RIGHT: 0%

BINAURAL HEARING LOSS: 0%

<PERCENT HEARING HANDICAP> (500, 1K, 2K, 3K HERTZ)

LEFT: 0%
RIGHT: 0%

BINAURAL HEARING HANDICAP: 0%

LASER INFORMATION

DATE: 10 OCT 80

NOTE: PULSED LASER IRRADIATION IN JOULES/CM2 CONTINUOUS LASER IN WATTS/CM2

NAME	Z NO	TA	BLDG	ROOM NO	LASER TYP	WAVE LGT MICRONS	IRRAD
[redacted]	087334	3	34	104	C	0.63	0.80 W/CM2
		6	70		C	0.51	1.0 W/CM2
[redacted]	055048	6	70	114	C	0.60	277.0 W/CM2
		6	70	114	C	0.60	16.7 W/CM2
		6	70	114	P	1.06	62.0 J/CM2
		6	70	114	L	0.65	0.40 W/CM2
[redacted]	044890	22	1	109	P	1.06	10.00 J/CM2
[redacted]	041502	35	HELIOS		P	10.6	0.10 J/CM2
		35	HELIOS		RP	10.6	0.10 W/CM2
		35	HELIOS		C	0.67	6.0 W/CM2
		35	HELIOS		L	10.6	4.0 W/CM2
[redacted]	074433	3	SM-40	S-14	P	10.6	19.0 J/CM2
		3	SM-40	S-14	C	10.6	0.67 W/CM2
[redacted]	082557	46	31		P	0.50	0.05 J/CM2
		46	31		RP	0.50	5.05 W/CM2
		46	31		L	0.63	0.02 W/CM2
[redacted]	082362	46	30	105	RP	0.25	0.06 W/CM2
[redacted]	083714	46	31	102	P	10.60	1.00 J/CM2
		46	31	102	RP	10.60	0.32 W/CM2
		46	31	102	C	0.63	0.06 W/CM2
[redacted]	041360	35	67		P	10.6	2.0 J/CM2
		35	67		L	10.6	0.39 W/CM2
		35	67		C	0.63	6.37 W/CM2
		35	67		L	0.65	127.4 W/CM2
[redacted]	070565	46	31	106	RP	1.06	0.64 W/CM2
[redacted]	082542	46	24	86	RP	10.6	0.64 W/CM2
		46	24	86	C	10.6	20.17 W/CM2
[redacted]	072754	3	SM-105	101	P	0.69	1202.0 J/CM2
		3	SM-105	101	L	0.63	0.64 W/CM2
[redacted]	084055	35	TSL-86	100	P	10.6	0.10 J/CM2
		35	TSL-86	100	RP	10.6	2.0 W/CM2
		35	TSL-86	100	L	10.6	4.0 W/CM2
		35	TSL-86	100	C	0.67	6.0 W/CM2
[redacted]	085120	3	267	211	L	10.60	50.50 W/CM2
[redacted]	082042	35	46		P	1.06	0.47 J/CM2
[redacted]	082264	0			L	0.63	0.51 W/CM2
					L		W/CM2

*=5 YEARS OR OVER SINCE PHYSICAL **=10 YEARS OR OVER SINCE PHYSICAL

DATE DUE	INT YRS	DATE LAST	NAME	TELE		Z NO
80/01	3	77/01		667-4541	009437	25,43,628.84
79/09	3	76/09		667-4745	085274	25,58,252.25
*80/10	5	75/10		667-6965	083944	25,21,045.85
79/06	3	76/06		667-4686	071757	25,21,38.65
*74/08	3-K	71/08		667-2074	009986	25,15,214.60
80/08	3	77/08		667-6052	074026	25,68,447.84
80/03	3	77/03		667-2556	071436	25,50,641.25
80/01	3	77/01		667-5729	080345	25,72,225.85
79/03	3	76/03		667-4671	023744	25,34,426.65
79/10	1	78/10		667-4653	009267	25,47,103.17
80/09	3	77/09		667-5327	061417	25,25,433.25
79/05	3	76/05		667-7320	009750	25,60,45.25
79/11	3	76/11		667-6704	085702	25,41,55.85
79/08	2	77/08		667-4807	021935	25,51,625.25
80/08	3	77/08		667-6126	072316	25,16,620.55
80/08	3	77/08		667-2134	077547	25,5,69.54
80/02	3	77/02		667-5405	076730	53,37,105.85
80/10	2	78/10		667-5529	075657	53,16,411.15
*80/05	5	75/05		667-2014	083393	53,12,42.33
*80/07	5	75/07		667-4656	083454	53,20,276.55
79/12	3	76/12		667-4401	081266	53,6,434.62
79/05	3	76/05		667-4656	066904	53,51,221.15
79/04	3	76/04		667-7423	083772	53,50,265.25
80/04	1	79/04		667-3073	063938	53,76,903.05
79/04	3	76/04		667-7746	070510	53,55,422.75
80/01	3	77/01		667-6370	064245	53,22,231.25
80/01	3	77/01		667-5303	065191	53,61,309.53
80/07	3	77/07		667-2449	073576	53,46,37.53
79/03	3	76/03		667-4544	064408	53,67,35.64
80/03	3	77/03		667-2530	085056	53,64,629.53
79/01	1	78/01		667-6354	002448	53,42,235.25
78/11	3	75/11		667-4564	078060	53,82,265.65
80/04	3	77/04		667-4761	022054	53,23,423.04
80/02	3	77/02		667-7102	060306	53,13,646.94
79/07	3	76/07		667-2677	079420	53,27,635.65
79/12	2	77/12		667-5400	015549	53,2,613.25
80/09	2	78/09		667-6306	073111	53,51,627.31
*80/04	5	75/04		667-5234	084077	53,0,235.65
79/05	3	76/05		667-2656	077102	65,60,420.44
79/05	2	77/05		667-3030	086543	65,60,21.01
80/09	3	77/09		667-4606	081509	65,74,678.54

USING FRAMINGHAM STUDY STATISTICS, BASED UPON PROFILE OF: [redacted]
AGE=36 SEX: MALE HEIGHT: 75 INCHES WEIGHT: 180 LBS
PRESENTLY SMOKING
LVH VIA EKG NOT PRESENT
GLUCOSE INTOLERANCE NOT PRESENT
GLUCOSE VALUE=117 (FASTING BLOOD)
CHOLESTEROL VALUE=335
SITTING BP VALUE=105

HERE IS 11.3% POSSIBILITY (11.3 IN 100) OF DEVELOPING CORONARY
HEART DISEASE IN 6 YEARS. ***** RISK IS BEYOND TABLE LIMITS! *****

HIS RISK CAN BE REDUCED FROM 11.3% TO 0.5% BY:
REDUCE CHOLESTEROL TO 210
QUIT SMOKING

OTHER RISK REDUCTION IF PATIENT'S WEIGHT (180 LBS) IS WITHIN LIMITS:
SMALL FRAME: 159-170
MEDIUM FRAME: 167-185
LARGE FRAME: 177-199

USING FRAMINGHAM STUDY STATISTICS, BASED UPON PROFILE OF: [redacted]
AGE=47 SEX: MALE HEIGHT: 66 INCHES WEIGHT: 182 LBS
PRESENTLY SMOKING
LVH VIA EKG NOT PRESENT
GLUCOSE INTOLERANCE NOT PRESENT
GLUCOSE VALUE=105 (3 HR AFTER EATING)
CHOLESTEROL VALUE=260
SITTING BP VALUE=150

HERE IS 16.9% POSSIBILITY (16.9 IN 100) OF DEVELOPING CORONARY
HEART DISEASE IN 6 YEARS.

HIS RISK CAN BE REDUCED FROM 16.9% TO 5.2% BY:
REDUCE CHOLESTEROL TO 255
REDUCE BLOOD PRESSURE TO 135
QUIT SMOKING

OTHER RISK REDUCTION IF PATIENT'S WEIGHT (182 LBS) IS WITHIN LIMITS:
SMALL FRAME: 123-132
MEDIUM FRAME: 129-142
LARGE FRAME: 137-156

TELEMED EKG REPORT DATED: 6 JUN 80

NAME: [redacted] PATIENT ID: [redacted]

INTERVALS:	PR=0.14	QRS(LIMB)=0.084	QT=0.36
AXES:	P =58	QRS =65	T =31

PATIENT DATA: PATIENT IS A FEMALE, AGE 40 AND OF LARGE BODY BUILD FOR ROUTINE ECG WITH NO PERTINENT CLINICAL HISTORY AND IS TAKING NO SPECIFIED DRUGS

INTERPRETATION:(SUMMARY) SINUS RHYTHM - RATE=80
ECG WITHIN NORMAL LIMITS

TELEMED ECG REPORT DATED: 16 MAY 00

NAME: [redacted] PATIENT ID: [redacted]

INTERVALS:	PR=0.15	QRS(LIMB)=0.114	QT=0.44
AXES:	P 8=10	QRS 8101	T 864

PATIENT DATA: PATIENT IS A MALE, AGE 25 AND UP AVERAGE BODY BUILD FOR ROUTINE ECG WITH NO PERTINENT CLINICAL HISTORY AND IS TAKING NO SPECIFIED DRUGS

INTERPRETATION:(SUMMARY) MARKED SINUS BRADY - RATE=48
- MARKED RATE VARIATION
-NONSP QRS WIDENING.
-RIGHT AXIS -? NORMAL FOR AGE.
-INFERIOR ST-ELEVATION -? REPOLARIZATION VARIANT.
ECG BORDERLINE

OFFICE MEMORANDUM

6 AUG 60

TO : GROUP LEADERS, L-DO MS 526

FROM : [redacted], H-2

SUBJECT : LASER PERSONNEL SCHEDULED FOR OPHTHOLOGY EXAM - [redacted]

SYMBOL : H-2

MAIL STOP: 421

[redacted], FROM YOUR GROUP HAS BEEN SCHEDULED FOR AN OPHTHOLOGY EXAM WITH DR. [redacted] ON AUGUST 7, 1960, AT 9:00 AM.

SINCE DR. [redacted] HAS TO MAKE SEVERAL ADJUSTMENTS TO HIS EQUIPMENT, HE PREFERS TO SET ASIDE AN ENTIRE MORNING OR A WHOLE DAY FOR THIS TYPE OF EXAMINATION. THEREFORE, IT IS IMPORTANT THAT THE SCHEDULED PERSON REPORT TO HIS OFFICE, IN THE LOS ALAMOS MEDICAL CENTER, WHEN SCHEDULED.

IT IS H-2'S POLICY TO PAY FOR THIS EXAM FOR EMPLOYEES OF THE LOS ALAMOS SCIENTIFIC LABORATORY. HOWEVER, IT IS DR. [redacted] POLICY TO CHARGE FOR ALL SCHEDULED PEOPLE WHETHER THEY SHOW UP AS SCHEDULED OR NOT. THE CHARGE FOR ALL 'NO-SHOWS' WILL BE RE-CHARGED TO THAT PERSON'S GROUP.

THIS TIME AND DATE HAS BEEN AGREED TO BY YOUR EMPLOYEE. THIS MEMO IS TO MAKE THE GROUP OFFICE AWARE OF THIS APPOINTMENT AND TO SERVE AS LAST MINUTE NOTIFICATION TO THE EMPLOYEE.

PLEASE INFORM [redacted] AT 667-7846 AS SOON AS POSSIBLE IF EMPLOYEE CANNOT KEEP THIS APPOINTMENT. CANCELLATIONS 24 HOURS IN ADVANCE WILL NOT BE RECHARGED.

CC: H-2 FILE

SSN: [redacted]

AAL PROFILE

CHEMISTRY PROFILE
SSN: [redacted]

	NORMALS	H/L	06-04-80 SFH	06-06-79 SFH
CALCIUM	8.50-10.4		9.5	9.60
IN PHOS	2.00-4.30		2.3	2.20
GLUCOSE	60.0-115.		106.0	111.0
BUN	8.00-24.0		15.0	11.0
URIC AC	3.90-9.00		5.9	6.50
CHOLEST	120.-250.		152.0	166.0
TOT PRO	6.20-8.50		6.8	6.90
ALBUMIN	3.40-5.00		4.1	4.20
GLOBULN	2.20-3.00		2.70	2.70
A/G	0.00-999.		1.51	1.55
TOT BIL	0.20-1.30		0.4	0.30
ALK PHO	30.0-125.		86.0	90.0
LDH	60.0-225.		176.0	----.0
SGOT	8.00-30.0		12.0	17.0
SGPT	6.00-37.0		17.0	20.0
CREAT	0.50-1.50		1.2	1.20
BUN/CRT	9.00-24.0		12.50	9.16
IRON	0.00-999.		.0	.0
TRIG	30.0-170.		114.0	126.0
SODIUM	134.-145.		144.0	142.0
POTAS	3.40-5.20		4.3	4.60
CHLORID	99.0-111.		104.0	107.0
TOT BAS	0.00-999.		.0	.0
T4 RIA	4.50-12.5		7.3	8.2
GAM GTP	0.00-50.0		47.0	55.0
CO2	20.0-30.0		26.0	27.0
HDL CHL	25.0-45.0		24.0	24.0
DIR BIL	0.00-0.30		0.1	0.10

BLOOD PROFILE

NAME: [redacted]

CHEMISTRY PROFILE
SSN: [redacted]

	NORMALS	H/L	05-12-80 SFH	05-08-74 SFH
CALCIUM	8.50-10.4		9.8	10.1
IN PHOS	2.00-4.30		3.3	3.3
GLUCOSE	60.0-115.		105.0	105.0
BUN	8.00-24.0		11.0	24.0
URIC AC	3.90-9.00		7.7	8.2
CHOLEST	120.-250.	H	256.0	221.0
TOT PRO	6.20-8.50		7.8	7.5
ALBUMIN	3.40-5.00		4.3	4.5
GLOBULN	2.20-3.60		3.50	2.80
A/G	0.00-999.		1.22	1.88
TOT BIL	0.20-1.30		0.6	0.8
ALK PHO	30.0-125.	H	140.0	66.0
LDH	60.0-225.	H	240.0	141.0
SGOT	8.00-36.0	H	214.0	13.0
SGPT	6.00-37.0	H	263.0	15.0
CREAT	0.50-1.50		0.8	1.3
BUN/CRT	9.00-24.0		13.75	18.46
IRON	0.00-999.		.0	.0
TRIG	30.0-170.		143.0	304.0
SODIUM	134.-145.		143.0	144.0
POTAS	3.40-5.20		4.3	5.1
CHLORID	99.0-111.		104.0	110.0
TOT GAS	0.00-999.		.0	.0
14 HIA	4.50-12.5		9.4	6.6
GAM GTP	0.00-50.0	H	274.0	47.0
CO2	20.0-30.0		28.0	25.0
HDL CHL	25.0-45.0	H	64.0	42.0
DIR BIL	0.00-0.30		0.3	0.2

[redacted]
EXAM 03/07/78 72345
INDUSTRIAL CHEMCO/OHIO
321 MAIN STREET
CLEVELAND OH 44100
MALE AGE 44 WHITE

SS [redacted]
DOB 07/02/1933
OCC-LINE FOREMAN
0022-5038
REPORT 10/06/78

Diamond Shamrock.
Diamond Shamrock Health System

ADVISORY PHYSICIAN
[redacted] MD
654 MAIN STREET
CLEVELAND OH 44100

		03/12/78								
PROBLEM SUMMARY - PRESENT										
RESPIRATORY										
SMOKED CIGS 10-20 YRS		*								
RETICULO-ENDOTHELIAL										
PENICILLIN ALLERGY		**								
GENITO-URINARY										
7-24 ALC. DRINKS/WK		*								
NOCTURIA 2-3 TIMES		**								
METABOLIC ENDOCRINE										
RECENT INCREASED THIRST		**								
RECENT INCREASE URINATION		**								
NEUROLOGICAL										
HEADACHES-BACK OF NECK		*								
MUSCULO-SKELETAL AND SKIN										
LOST 10/MORE LBS 6 MON		**								
BLOOD PRESSURE										
(90-140 MM)	SYSTOLIC	170	H							
(40- 90 MM)	DIASTOLIC	100	H							
VISION										
	FAR-RIGHT	20/ 40	H							
HEMATOLOGY										
(14.0-18.0 GM)	HGB	13.4	L							
(42.0-52.0 %)	HCT	38.0	L							
SERUM CHEMISTRY										
(65-115 MG)	GLUC	260	H							
(150-300 MG)	CHOL	365	H							
URINALYSIS										
	GLUCOSE	2+	H							
	KETONE	1+	H							
PHYSICIAN'S EXAMINATION										
EXCESS EAR WAX-R		**								
DENTAL CARIES		**								

[redacted]
EXAM 03/07/78 72345
INDUSTRIAL CHEMCO/OHIO
321 MAIN STREET
CLEVELAND OH 44100
MALE AGE 44 WHITE

Diamond Shamrock
Diamond Shamrock Health Systems

	02/19/74	03/15/75	02/26/76	01/12/77	03/12/78
FAMILY MEDICAL HISTORY					
HYPERTENSION	••	••	••	••	••
DIABETES	••	••	••	••	••
STROKE	••	••	••	••	••
FATHER DIED UNDER AGE 60	••	••	••	••	••
MOTHER DIED OVER AGE 70	••	••	••	••	••
SPOUSE GENERALLY HEALTHY	••	••	••	••	••
PERSONAL MEDICAL HISTORY					
HOSPITAL OVER 3 YRS AGO	••	••	••	••	••
HAY FEVER	••	••	••	••	••
SINUS PROBLEM	••	••	••	••	••
HYPERTENSION			••	••	••
GUM INFECTIONS	••	••	••	••	••
PAST SURGERY					
TONSILS	••	••	••	••	••
APPENDIX	••	••	••	••	••
DIET & MEDICATION					
ANTIHISTAMINES	••	••	••	••	••
ASPIRIN/APC	••	••	••	••	••
BLOOD PRESSURE MEDICATION		••	••	••	••
RESPIRATORY					
4-8 COLDS PAST YEAR			*		
SMOKES 1 PK/DAY	*	*	*		
SMOKED CIGS 10-20 YRS	*	*	*	*	*
QUIT CIGS 1-5 YRS AGO				••	••
CARDIOVASCULAR					
DYSPNEA 1 FL STAIRS			**		
DIGESTIVE					
DAILY BOWEL MOVEMENT	••	••	••	••	••
RECENTLY FIRM STOOLS	••	••	••	••	••
RETICULO-ENDOTHELIAL					
PENICILLIN ALLERGY	**	**	**	**	**
VACCINATION-OVER 3 YRS	••	••	••	••	••
GENITO-URINARY					
UNDER 6 ALC DRINKS/WK	••	••			
7-24 ALC DRINKS/WK			*	*	*
URINE 7-10 TIMES/DAY					••
NOCTURIA 2-3 TIMES					**
METABOLIC ENDOCRINE					
RECENT INCREASED THIRST					••
RECENT INCREASE URINATION					••

[redacted]
EXAM 03/07/78 72345
INDUSTRIAL CHEMCO/OHIO
321 MAIN STREET
CLEVELAND OH 44100
MALE AGE 44 WHITE

Diamond Shamrock
Diamond Shamrock Health System

	02/19/74	03/15/75	02/26/76	01/12/77	03/12/78
NEUROLOGICAL					
WEARS GLASSES	••	••	••	••	••
SLEEPS 6-8 HRS	••	••	••	••	••
HEADACHES-BACK OF NECK			*	*	*
MUSCULO-SKELETAL AND SKIN					
LOW BACKACHE/PAIN	••	••			
NO SPECIAL EXERCISE	••	••	••	••	••
LOST 10/MORE LBS 6 MOS					**
PHYSICAL MEASUREMENTS					
HEIGHT (IN)	68.5	68.5	68.5	68.5	68.5
WEIGHT (LB)	183	187	179	180	162
AUDIOMETRY					
(0-25 DB) 500 HZ LEFT	10	05	10	10	10
1000 HZ LEFT	10	05	10	15	15
2000 HZ LEFT	05	10	10	10	10
3000 HZ LEFT	10	10	15	20	20
4000 HZ LEFT	10	10	10	15	20
6000 HZ LEFT	15	10	15	20	25
8000 HZ LEFT	15	20	15	15	20
500 HZ RIGHT	05	00	05	05	05
1000 HZ RIGHT	10	10	10	10	10
2000 HZ RIGHT	10	05	10	10	05
3000 HZ RIGHT	10	15	10	15	15
4000 HZ RIGHT	15	10	15	15	15
6000 HZ RIGHT	05	10	15	15	15
8000 HZ RIGHT	05	05	10	10	10
SPIROMETRY					
(570 L) PFR	540	520	485	540	545
(4.20 L) FVC	3.60	3.50	3.55	3.60	3.50
(3.34 L) FEV-1 SEC	3.24	3.08	2.91	L 3.02	3.00
(80%) FEV-1/FVC	90	88	82	84	86
(4.07 L) FEV-3 SEC	3.42	3.29	3.30	3.38	3.30
(97%) FEV-3/FVC	95	94	93	94	94
BLOOD PRESSURE					
(90-140 MM) SYSTOLIC	138	162 H	158 H	155 H	160 H
(40- 90 MM) DIASTOLIC	86	98 H	96 H	98 H	100 H
PULSE RATE					
(50-99/MIN)	72	66	68	70	72
VISION					
GLASSES-NEAR ONLY					
(20/20) FAR- BOTH	20/ 30	20/ 30	20/ 30	20/ 30	20/ 30
FAR-RIGHT	20/ 25	20/ 30	20/ 35	20/ 35	20/ 40 *
FAR- LEFT	20/ 20	20/ 25	20/ 20	20/ 20	20/ 20
NEAR- BOTH	20/ 20	20/ 20	20/ 25	20/ 25	20/ 25
NEAR-RIGHT	20/ 25	20/ 25	20/ 25	20/ 25	20/ 25
NEAR- LEFT	20/ 20	20/ 25	20/ 25	20/ 25	20/ 25

[redacted]
EXAM 03/07/78 72345
INDUSTRIAL CHEMCO/OHIO
321 MAIN STREET
CLEVELAND OH 44100
MALE AGE 44 WHITE

Diamond Shamrock
Diamond Shamrock Health System

		02/19/74	03/15/75	02/26/76	01/12/77	03/12/78	
	COLOR	NORMAL	NORMAL	NORMAL	NORMAL	NORMAL	
	DEPTH	NORMAL	NORMAL	NORMAL	NORMAL	NORMAL	
	PHORIA	NORMAL	NORMAL	NORMAL	NORMAL	NORMAL	
OCULAR TENSION							
(6-26 MG)	RIGHT	16	16	18	20	22	
	LEFT	14	16	18	20	24	
HEMATOLOGY							
(4.8-10.8)	WBC	7.3	7.2	7.9	7.6	7.5	
(4.7-6.1)	RBC	4.95	4.80	4.85	4.75	4.70	
(14.0-18.0)	HGB	14.5	14.8	15.2	14.2	13.4	L
(42.0-52.0)	HCT	44.5	44.0	42.6	42.2	38.0	L
(80-94)	MCV	89.9	91.7	87.8	88.8	80.9	
(27.0-31.0)	MCH	29.3	30.8	31.3	H 29.9	28.5	
(32.0-36.0)	MCHC	32.6	33.6	35.7	33.6	35.3	
SERUM CHEMISTRY							
FASTING STATE		FASTING	FASTING	FASTING	FASTING	FASTING	
(8.2-10.5 MG)	CALC	10.4	9.8	9.6	10.1	10.2	
(2.5-4.5 MG)	PHOS	3.8	3.6	3.2	3.6	3.8	
(65-115 MG)	GLUC	92	98	105	110	260	H
(7-26 MG)	BUN	14	10	15	11	12	
(4.0-8.5 MG)	URIC	5.2	5.6	5.9	6.4	7.0	
(150-300 MG)	CHOL	200	240	285	295	365	H
(6.0-8.0 GM)	T.P.	7.6	7.3	7.7	7.5	7.8	
(3.5-5.0 GM)	ALB	4.8	4.1	3.9	4.0	4.4	
(0.2-1.2 MG)	BILI	0.7	0.8	0.6	0.8	0.9	
(30-115 IU)	ALC-P	82	87	91	94	106	
(100-225 IU)	LDH	145	170	155	180	160	
(7-40 IU)	SGOT	24	28	32	36	38	
(8-37 IU)	GGTP	25	19	22	27	31	
(7-40 IU)	SGPT	17	12	20	21	25	
(30-200 MG)	TRIGL	140	125	135	120	110	
(2.0-3.5 GM)	GLOB	2.4	2.6	2.5	2.8	2.2	
(1.0-2.5)	A/G	2.0	1.6	1.6	1.5	2.0	
(0.4-1.5 MG)	CREAT	0.8	0.9	1.2	1.0	1.1	
(7-28)	BUN/CREAT	17	19	24	18	11	
(135-147 MEQ)	NA	138	136	142	140	139	
(3.5-5.5 MEQ)	K	4.4	3.9	4.0	4.6	4.8	
(98-108 MEQ)	CHLOR	104	100	102	106	102	
(22-33 MEQ)	CO2	25	24	27	26	28	
(0-15 MEQ)	EL BAL	14	13	11	12	12	
URINALYSIS							
	COLOR	STRAW	STRAW	STRAW	STRAW	STRAW	
	CLARITY	CLEAR	CLEAR	CLEAR	CLEAR	CLEAR	
(3-30)	SP.GRAVITY	1.020	1.010	1.025	1.010	1.020	
(5.0-8.0)	PH	6.5	6.5	6.0	6.5	6.0	
	PROTEIN	NEG	NEG	NEG	NEG	NEG	
	GLUCOSE	NEG	NEG	NEG	NEG	2+	H
	KETONE	NEG	NEG	NEG	NEG	1+	H

[redacted]
EXAM 03/07/78 72345
INDUSTRIAL CHEMCO/OHIO
321 MAIN STREET
CLEVELAND OH 44100
MALE AGE 44 WHITE

Diamond Shamrock
Diamond Shamrock Health System

	02/19/74	03/15/75	02/26/76	01/12/77	03/12/78
OCC. BLOOD	NEG	NEG	NEG	NEG	NEG
BILE	NEG	NEG	NEG	NEG	NEG
MICROSCOPIC	NEG	NEG	NEG	NEG	NEG
ECG					
WITHIN NORMAL LIMITS	••	••	••	••	••
X-RAY					
NO SIGNIF. ABNORMALITY	••	••	••	••	••
PHYSICIAN'S EXAMINATION					
EXCESS EAR WAX-R				••	••
EXTERNAL OTITIS-L		••			
DENTAL CARIES	••				••
HOARSENESS		••	••		
WHEEZING		••	••		

Unscheduled Health Events Input

Personal Injury Report

Data Element	Responses
Installation	numeric
Injured employee ID number	numeric
Date of injury	numeric
Time of injury	numeric or code for AM/PM
Accident investigation report filed?	yes
	no
Location of accident	numeric (grid code) or code for off-premise
Duty status at time of accident	on duty, on premises
	on duty, local travel
	on duty, out-of-town travel
	duty status questionable
	not on duty
Accident witnessed?	yes
	no
Nature of injury (1)	numeric (HICDA code)
(2)	numeric (HICDA code)
(3)	numeric (HICDA code)
Cause of injury	numeric (HICDA code)
NASA health unit treatment (day of injury)	first aid only
	first aid plus PHS referral
	first aid plus PMD or clinic referral
	first aid plus hospital ER referral
	first aid plus hospital inpatient referral
	not seen
NASA health unit estimate of disability (day of injury)	none
	partial temporary
	total temporary
	partial permanent
	total permanent
	fatality
	not seen
NASA health unit disposition (day of injury)	return to regular work, full time
	return to regular work, part time
	return to limited duty, full time
	return to limited duty, part time
	to non-duty status
	not seen
Non-NASA physician estimate of disability (upon first visit)	none
	partial temporary
	total temporary
	partial permanent
	total permanent
	fatality
	not seen
Outside medical expense?	yes
	no
Lost time or restricted work activity?	yes
	no

Data Element	Responses
Compensation claim	not filed claim withdrawn to Personnel file to OWCP
Number of total work days lost	numeric
Number of partial work days lost	numeric
Number of calendar days lost	numeric
Type of leave charge	COP sick leave annual leave other
Date of first work absence	numeric
Date of final return to work	numeric
Total cost of COP	numeric (cents?)
Number work days of restricted duty	numeric
Nature of physical limitations	?coding system - likely to be multiple
Claim controverted?	yes no
Basis of controversion	not "traumatic" injury not job-related not disabling misconduct, intoxication or intent late filing delayed disability not controverted
Controversion sustained?	yes no not controverted
Third party liability?	yes no
OWCP file number	numeric
Total medical costs	numeric)
Total disability costs	numeric) to be input from
Total fatality costs	numeric) chargeback bill

JSC

X 10

RECORD OF INJURY

Form will be originated in triplicate at the Dispensary and given to patient. Patient will deliver to supervisor who will complete all blocks in Section I and forward to Industrial Safety Office located in Building 100.

SECTION I

LAST NAME, FIRST NAME, MIDDLE INITIAL	SEX	AGE	GRADE AND JOB TITLE

CODE AND NAME OF ORGANIZATION	PHONE NO.	INJURY		RETURN TO WORK		EXACT LOCATION OF ACCIDENT
		HOUR	DATE	HOUR	DATE	

OCCUPATION OR DUTY WHEN INJURED	NORMAL OCCUPATION IF DIFFERENT	WITNESS

HOW INJURY OCCURRED: *(Explain exactly what injured was doing and what unsafe act or condition caused the accident.)*

ACTION TAKEN TO PREVENT RECURRENCE	SIGNATURE OF SUPERVISOR	DATE

SECTION II - *To be completed by Medical Officer or Attendant.*

NATURE AND EXTENT OF INJURY OR OCCUPATIONAL ILLNESS

DISPOSITION *(Check one)* ☐ RETURN TO REGULAR ASSIGNMENT ☐ RETURN TO WORK OF LIGHT NATURE ☐ HOSPITAL

☐ REFERRED TO USPHS ☐ SENT HOME TO RETURN FOR FURTHER TREATMENT ☐ OTHER _____ (SPECIFY)

ESTIMATED ABSENCE IN DAYS BEYOND DAY ON WHICH INJURY OCCURRED	SIGNATURE OF MEDICAL OFFICER OR ATTENDANT	DATE

JSC Form 340 ((Rev Oct 68) NASA-JSC

Occupational Safety and Health Administration
Supplementary Record of Federal Occupational Injuries and Illnesses

U.S. Department of Labor

Agency

1. Name | Case or File Number

2. Mail Address *(No. & Street)* *(City/Town)* *(State)*

3. Location, if different from mail address

Injured or Ill Employee

4. Name *(First)* *(Middle)* *(Last)* Social Security Number

5. Home Address *(No. & Street)* *(City/Town)* *(State)*

6. Age 7. Sex Male ☐ Female ☐ 8. Job Title

9. Department (Enter name of department or division in which the injured person is regularly employed, even though he may have been temporarily working in another department at the time of injury.)

The Accident or Exposure to Occupational Illness

10. Location of Accident or Exposure (If accident or exposure occurred on Agency's premises, give address of plant or establishment in which it occurred. Do not indicate department or division within the plant or establishment. If accident occurred outside Agency's premises at an identifiable address, give that address. If it occurred on a public highway or at any other place which cannot be identified by number and street, please provide place references locating the place of injury as accurately as possible.)
(No. & Street) *(City/Town)* *(State)*

11. Was location of accident or exposure on Agency's premises? Yes ☐ No ☐

12. What was the employee doing when injured? (Be specific. If he was using tools or equipment or handling material, name them and tell what he was doing with them. Use separate sheet for additional space.)

13. How did the accident occur? (Describe fully the events which resulted in the injury or occupational illness. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident. Use separate sheet for additional space.)

Occupational Injury or Occupational Illness

14. Describe the injury or illness in detail and indicate the part of body affected. (e.g., amputation of right index finger at second joint; fracture of ribs; lead poisoning; dermatitis of left hand, etc.)

15. Name the object or substance which directly injured the employee. (For example, the machine or thing he struck against or which struck him; the vapor or poison he inhaled or swallowed; the chemical or radiation which irritated his skin; or in cases of strains, hernias, etc, the thing he was lifting, pulling, etc.)

16. Date of injury or initial diagnosis of occupational illness and did employee die? Yes ☐ No ☐

17. Did the injury or illness result in days away from work or days of restricted work activity? If yes, how many?

Other

18. Name and Address of Physician

19. If hospitalized, name and address of hospital

Date of Report | Prepared By | Official Position

JSC.

Standard Form 601
Nov. 1952
Bureau of the Budget
Circular A-5.

HEALTH RECORD — IMMUNIZATION RECORD

All entries in ink to be made in block letters.

VACCINATION AGAINST SMALLPOX (*Number of previous vaccination scars*)

	DATE	ORIGIN	BATCH NUMBER	RESULT*		STATION	PHYSICIAN'S NAME
				3–5 DAYS	7–10 DAYS		
1							
2							
3							
4							
5							
6							

*ENTER RESULTS AS: IMMEDIATE REACTION (*of immunity*), ACCELERATED REACTION (*Vaccinoid*), TYPICAL PRIMARY VACCINA

TRIPLE TYPHOID VACCINE

	DATE	DOSE	UNTOWARD REACTION	PHYSICIAN'S NAME		DATE	DOSE	UNTOWARD REACTION	PHYSICIAN'S NAME
1					7				
2					8				
3					9				
4					10				
5					11				
6					12				

TETANUS TOXOID

	DATE	DOSE	UNTOWARD REACTION	PHYSICIAN'S NAME		DATE	DOSE	UNTOWARD REACTION	PHYSICIAN'S NAME
1					4				
2					5				
3					6				

SCHICK TESTING AND DIPHTHERIA IMMUNIZATION

	DATE	DOSE	REACTION	PHYSICIAN'S NAME		DATE	DOSE	REACTION	PHYSICIAN'S NAME
	TEST					TEST			
1					5				
2					6				
3					7				
4					8				

TYPHUS VACCINE

	DATE	DOSE	REACTION	PHYSICIAN'S NAME		DATE	DOSE	REACTION	PHYSICIAN'S NAME
1					4				
2					5				
3					6				

CHOLERA VACCINE

	DATE	ORIGIN	BATCH NO.	PHYSICIAN'S NAME		DATE	ORIGIN	BATCH NO.	PHYSICIAN'S NAME
1					7				
2					8				
3					9				
4					10				
5					11				
6					12				

YELLOW FEVER VACCINE

	DATE	ORIGIN	BATCH NO.	STATION	PHYSICIAN'S NAME
1					
2					
3					

SEX	RACE	GRADE, RATING OR POSITION	ORGANIZATION UNIT	COMPONENT OR BRANCH	SERVICE, DEPT. OR AGENCY

PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME	DATE OF BIRTH (DAY–MONTH–YEAR)	IDENTIFICATION NO.

OTHER IMMUNIZATIONS

	DATE	TYPE	DOSE	REACTION	REMARKS	PHYSICIAN'S NAME
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

SENSITIVITY TESTS (*Tuberculin, etc.*)

	DATE	TYPE	DOSE	ROUTE	RESULTS	PHYSICIAN'S NAME
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

REACTIONS (*To transfusions, drugs, sera, foods, allergens, etc.*)

	DATE	AGENT	TYPE OF REACTION	SEVERITY	PHYSICIAN'S NAME
1					
2					
3					
4					
5					

BLOOD TYPING

	DATE	TYPE (*International*)	Rh FACTOR	PHYSICIAN'S NAME
1				
2				
3				

REMARKS AND RECOMMENDATIONS (*Including history of diseases for which any of the above immunizing agents were given with year and place of attack*)

THIS RECORD IS ISSUED IN ACCORDANCE WITH ARTICLE 99, WHO SANITARY REGULATION NO. 2.

U.S. GOVERNMENT PRINTING OFFICE: 1961 O—580884

GODDARD SPACE FLIGHT CENTER
MEDICAL RECORD OF INJURY
CIVIL SERVICE EMPLOYEE

SOCIAL SECURITY NUMBER	REFERENCE NUMBER

NAME (LAST)	(FIRST)	(MIDDLE)	ORG/CODE	POSITION TITLE

Date of Birth	SEX	TELEPHONE	SUPERVISOR	EXACT LOCATION INJURY OCCURRED

INJURED (Date & Time)	APPLIED FOR TREATMENT (Date & Time)	EXACT NATURE OF INJURY

FACTUAL STATEMENT OF OCCURRENCE OF INJURY: (Detail)

INJURY CLASSIFICATION (Check One)

☐ Occupational ☐ Non-Occupational ☐ Questionable

IS INJURY DISABLING? (Check One) **IF YES - APPROXIMATE NUMBER OF DAYS DISABILITY**

☐ Yes ☐ No ☐ Possibly

DISPOSITION (Check One)

☐ Returned to Work ☐ Light Duty ☐ Sent Home ☐ Referred to Private Physician ☐ Other

Is Injury Reportable to DOL Under OSHA Guidelines? ☐ Yes ☐ No ☐ Unknown

PHYSICAL FINDINGS:

DIAGNOSIS:

TREATMENT RENDERED:

SIGNATURE OF MEDICAL OFFICER:

GSFC 23-28 (6/75)

Fitness for Duty (Input and Output)

NASA AMES RESEARCH CENTER

PHYSICAL LIMITATIONS REPORT

Name_____ Date _____

Division_____

This Employee should <u>not</u> be assigned a job requiring:

- ☐ 1. Any lifting over _____ pounds.
- ☐ 2. Anything other than bench or desk work.
- ☐ 3. Repeated bending or working in cramped positions.
- ☐ 4. Kneeling.
- ☐ 5. Two handed dexterity.
- ☐ 6. Continuous walking.
- ☐ 7. Continuous standing.
- ☐ 8. Work on ladders or overhead.
- ☐ 9. Climbing ladders or scaffolds.
- ☐ 10. Climbing stairs or ramps.
- ☐ 11. Accurate far vision.
- ☐ 12. Accurate near vision.
- ☐ 13. True color perception.
- ☐ 14. True depth perception.
- ☐ 15. Work around moving machinery.
- ☐ 16. Operate moving machinery.
- ☐ 17. Crane or motor vehicle operation.
- ☐ 18. Exposure to skin irritants.
- ☐ 19. Other_____

_____

_____

Expected period of disability_____

_____

Physician's signature

DSD: 030

KSC

PHYSICAL LIMITATION EVALUATION

TO: AD-PER-4/Staffing and Personnel Services Branch

THRU: MD-O/Occupational Health

FROM: Contract Medical Director

1. Name (Last, First, Middle Initial)

2. Organization Mail Code	3. Birthdate	4. Employee No.

The above named NASA/KSC employee has been assigned handicapped code _____ based on physical examination of _____ (date) or review of medical records on _____ (date).

_____ Doctor's Signature

_____ Date

HANDICAP CODE

00 No handicap of the type listed
10 Amputation - one major extremity
11 Amputation - two or more major extremities
20 Deformity or impaired function - upper extremity
21 Deformity or impaired function - lower extremity or back
30 Vision - one eye only
31 No usable vision
40 Hearing aid required
41 No usable hearing
42 No usable hearing, with speech malfunction
43 Normal hearing, with speech malfunction
50 Tuberculosis - inactive pulmonary
51 Organic heart disease (compensated) - valvular, arrhythmia, arteriosclerosis, healed coronary lesions
52 Diabetes - controlled
53 Epilepsy - adequately controlled
54 History of emotional behavioral problems requiring special placement effort
55 Mentally retarded
56 Mentally restored

Personnel Staffing Specialist (Signature)	Personnel Management Specialist (Signature)	Administrative Section (Signature)

KSC FORM OT-300 (8-78) (ONETIME FORM - REPRINT NOT AUTHORIZED)

KSC

ENTRY PERMIT	Environmental Health Requirements for Entering Tanks and Confined Spaces (KHB 1840.1)

PART I - CONDITION

Location:	Date:	Time:

Designation:

Oxygen Content:	Toxic Gas Content:	Flammable Vapor:
		_____% of LEL (Lower Explosive Limit)

Atmospheric Classification:	Signature of Person Verifying PART I:
A_____ B_____	_____

PART II

I understand that the space named in Part I has been classified as Class _____(A or B), and personnel who will enter the space must be equipped with equipment approved for that class. All personnel involved have been instructed in the use of this equipment. I further understand that other applicable safety standards must be followed.

Operations to be Performed:

DURATION OF ENTRY: FROM _____(date) _____(time)
TO _____(date) _____(time)

Names of Entry Crew:	Date:
1.....	
2.....	Signature of Supervisor of Entry Crew:
3.....	

PART III

Environmental Health Comment:

KSC FORM 16-297 (6/78) NASA/KSC FEB/75

NASA - AMES RESEARCH CENTER

MEDICAL AUTHORIZATION TO RETURN TO WORK

DATE_____

_____HAS BEEN OFF WORK SINCE_____

DUE TO (INJURY, ILLNESS) OF (INDUSTRIAL, NON-INDUSTRIAL) NATURE AND HAS BEEN UNDER THE CARE OF_____. EXAM AT THE HEALTH UNIT (OR PERSONAL COMMUNICATION WITH _____) ON (_____) INDICATES (HE, SHE) MAY RETURN TO WORK ON _____ WITH THE FOLLOWING LIMITATIONS OR RECOMMENDATIONS:

_____

_____

_____

COMMENTS:_____

_____

_____

SIGNED:_____
Health Unit Physician

Original to Branch Chief
1st copy to Health Unit 215-8
2nd copy to Safety Office 201-7
3rd copy to Personnel Records 241-5

ARC 226 (May 1973)

Work History Input

OCCUPATIONAL AND MEDICAL HISTORY QUESTIONNAIRE
NASA MEDICAL SURVEILLANCE PROGRAM
FOR RESPIRATORY PROTECTIVE DEVICES

NAME OF EXAMINING FACILITY			
NAME (LAST)	(FIRST)	(M I.)	SOCIAL SECURITY NO. ☐☐☐-☐☐-☐☐☐☐
DATE OF THIS EVALUATION (Yr.) (Mo.) (Day) ☐☐-☐☐-☐☐	YRS GOV'T SER ☐☐	DATE OF BIRTH (Yr.) (Mo.) (Day) ☐☐-☐☐-☐☐	SEX ☐ M ☐ F
RACE ☐ 1 · Caucasian 2 · Negro 3 Other	STATUS ☐ 1. Government 2. Contractor		
CIVILIAN EMPLOYEE JOB TITLE	EXAM PURPOSE ☐	1 · Preplacement 2 · Annual 3 · Triannual 4 · Pentennual 5 · Termination	

ANSWER CODE (1) = YES (2) = NO (3) = N/A

PART I.

Occupational History

	Yes	No
1. Have you ever had a job where you were regulary exposed to:		
A. Asbestos dust		
B. Silica dust (sand)		
C. Coal dust		
D. Metal fumes or dust		
E. Irritant or noxious gases		
F. Plastic solvents (MEK, TDI)		
G. Other solvents (degreasers)		
H. Organic dust (cotton grain, wood dust, fungal spores)		
I. Other (specify)		
(_____)		

2. Have you ever worked (include part-time jobs and hobbies):

	Yes	No
As a hard rock, coal or uranium miner?		
As a quarryman, including sand?		
In a mill processing mined or quarried materials?		
In a foundry (at any job)?		
In abrasive blasting operations?		
In the pottery industry?		
In construction, insulation or shipyard work ?		
Where you were exposed to dust containing:		
asbestos		
talc		
diatomaceous earth		
dust from grinding or sanding		
As a welder ?		
Where you were required or chose to wear a respirator mask over your nose and mouth?		
In any other dusty job?		

To be completed by employee's supervisor

3. What type of respiratory protective equipment will be used, and what is its mode of operation (briefly describe)?

_____

_____

_____

4. What tasks will the employee perform while wearing the respirator?

_____

_____

_____

5. Would you consider this work to be:

sedentary	yes	no
mild exertion	yes	no
marked exertion	yes	no

(Note: Table 4 may be provided for reference.)

6. What visual and audio requirements are associated with his tasks?

_____

_____

_____

7. What length of time will the user wear the respiratory protective equipment?

_____

_____

_____

8. To what substance(s) will the employee be exposed, and what is the related toxicity data?

_____

_____

_____

_____

Supervisor Signature / Date

OCCUPATIONAL HEALTH EXAMINATION
PART I – HISTORY FORM

DATE

NAME _____ Employee No. _____

Code No. _____ Extension _____ Location _____

INSTRUCTIONS – Complete Items 1 thru 5.

1. DESCRIBE YOUR PRESENT SPECIFIC OCCUPATION.

2. ARE YOU NOW OR HAVE YOU EVER BEEN EXPOSED TO ANY OF THE FOLLOWING? (X APPROPRIATE BOXES)

- ☐ CHAMBER OPERATIONS INVOLVING HIGH OR LOW PRESSURE
- ☐ HIGH PLACES
- ☐ INTENSE NOISE OR VIBRATION
- ☐ OCCUPATIONS REQUIRING MANUAL DEXTERITY
- ☐ WORK IN CONFINED SPACES
- ☐ LASERS OR OTHER NON-IONIZING RADIATION
- ☐ DUSTY AREAS
- ☐ HEAVY LIFTING OR PUSHING
- ☐ OCCUPATIONS REQUIRING COLOR OR DEPTH PERCEPTION

DESCRIBE EACH ITEM CHECKED.

3. HAVE YOU BEEN REQUIRED TO USE THE FOLLOWING MATERIALS/EQUIPMENT IN YOUR PRESENT (OR PREVIOUS) OCCUPATIONS? (X APPROPRIATE BOXES)

- ☐ ASBESTOS
- ☐ LEAD
- ☐ PAINTS
- ☐ BERYLLIUM
- ☐ PLASTICS
- ☐ CHEMICALS
- ☐ SOLVENTS
- ☐ RADIATION
- ☐ WELDING
- ☐ AIRCRAFT
- ☐ RESPIRATORS
- ☐ POWER TOOLS
- ☐ GRINDING
- ☐ PLATING

DESCRIBE EACH ITEM CHECKED

4. DO YOU HAVE A HISTORY OF ANY JOB-INCURRED INJURY OR ILLNESS?

5. DESCRIBE YOUR HOBBIES AND RECREATIONAL ACTIVITIES.

(FOR HEALTH UNIT USE ONLY)

6. REMARKS

O H M S

EMPLOYEE HAZARD EXPERIENCE

NAME [redacted] DATE 4/21/77

JOB TITLE 'A' OPERATOR I.D. NO. 1005535

WORK AREA _____ AGE 54 SEX M

CHEMICAL/CONDITION	EXPOSURE LEVEL*	COMMENTS*
NOISE	2	
BUTADIENE	3	
STYRENE	3	
H2SO4	3	
SOD. HYDROXIDE	3	
POT. HYDROXIDE	3	
AMMONIA	3	

* EXPOSURE LEVELS: 1 = HIGH = ABOVE PERMISSIBLE LIMIT (MAC, TLV)
2 = MODERATE = ABOVE ACTION LEVEL BUT BELOW PERMISSIBLE LIMIT
3 = LIGHT = BELOW ACTION LEVEL
4 = MINIMAL = MINIMAL EXPOSURE OR NOT MEASURABLE
5 = UNDEFINED = MAY BE USED FOR PEAK EXCURSIONS OR SPECIAL INTERESTS, ETC.

* COMMENTS: SHOULD INDICATE PROTECTIVE EQUIPMENT SUCH AS RESPIRATORS, HEARING MUFFLERS, ETC. COULD INDICATE EXPOSURE TO EXCURSION LEVELS FOR THE SPECIFIC CHEMICAL OR CONDITION, CUMULATIVE PRIOR EXPOSURE, IF AVAILABLE, ETC.

BY [redacted]
IND. HYGIENIST, SAFETY SUPRV.

O H M S

EMPLOYEE HAZARD EXPERIENCE

NAME [redacted] DATE 4/21/77

JOB TITLE 'A' OPERATOR I.D. NO. 1005535

WORK AREA _____ AGE 54 SEX M

CHEMICAL/CONDITION	EXPOSURE LEVEL*	COMMENTS*
NOISE	2	
BUTADIENE	3	
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POT. HYDROXIDE	3	
AMMONIA	3	

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BY [redacted]
IND. HYGIENIST, SAFETY SUPRV.

Personal Protective Measures Input

NASA · AMES RESEARCH CENTER
Moffett Field, California

MEMORANDUM for Ames Safety Office
Ames Health Unit

From:

Subject: Authorization for Safety Protective Equipment

The work done by the employee listed below requires that he/she wear:
Check one box only. (Exception--boxes 1 and 2 may be checked together if employee's occupation requires sun glasses.)

- ☐ 1. Safety Glasses
- ☐ 2. Safety Sun Glasses
- ☐ 3. Laser Safety Goggles
- ☐ 4. Custom Fitted Ear Plugs
- ☐ 5. Safety Shoes
- ☐ 6. Other _____

☐ Eye Examination _____

☐ Laser Eye Examination _____

_____
Please Print Employee's Name

_____
Telephone Extension

_____
Organizational Code

_____
Mail Stop

_____
Signature of Branch Chief or Higher

Approved _____
John G. Habermeyer
Safety Officer

_____
Date

The above contract employee or student is eligible for safety glasses or other safety protective equipment as required by the work assigned to the contract employee or student and should be furnished at government expense as per Contract No. _____

_____
Contract Monitor

Note: Contract employee and students are not authorized for eye examinations and must furnish their own prescriptions for eye glasses if required.

ARC 169 (Rev. Jun 75)

Table 3

MEDICAL APPROVAL FORM

Upon completion of a medical screening examination to verify this individual's capability to wear a respirator, I recommend this person for a:

☐ Standard certificate

☐ Restricted certificate bearing the following qualifications (encircle appropriate statement):

a. Not qualified to wear breathing apparatus in irrespirable atmospheres because of age or some physical impairment, but is qualified to maintain such apparatus.

b. Qualified to wear breathing apparatus or auxiliary rescue equipment with facepiece, provided all removable bridges or dentures are removed from mouth.

c. Qualified to wear breathing apparatus or auxiliary rescue equipment with facepiece, provided such facepiece is so equipped that vision can be corrected with corrective lens.

d. Qualified to wear breathing apparatus (i.e., mouthpiece) in compressed air only.

e. Qualified to wear powered respirator only.

Signed _____

Title _____

Source: Mining Enforcement and Safety Administration. *Physician's examination form.* Form #5000-3. U.S. Dept. of Interior, July 1974.

Personalized Exposure Measurement Input

KSC

PERSONNEL MONITORING DATA SHEET

Name _____ (Print) Date: _____

Social Security No. _____ Time: _____

Company _____ Local Tel. No.: _____

Address _____ Home Tel. No.: _____ (Area Code)

Wearing respiratory protection Yes _____ No _____

Wearing protective clothing Yes _____ No _____

Nose Wipe Sample No. _____

Sputum sample No. _____

Monitoring Data

Instrument: PRM-5/PG-2 _____ PRM-5/Fidler _____ Pac _____

Area	Before Decon.	After Decon.	Repeat
1			
2			
3			
4			
5			
6			
8			
9			

Remarks:

Monitor _____

Decon Area _____

Form FSSH—Rad-8
(1-64)

OCCUPATIONAL EXTERNAL RADIATION EXPOSURE HISTORY

See Instructions on the Back

IDENTIFICATION

1. NAME (PRINT—LAST, FIRST, AND MIDDLE)	2. SOCIAL SECURITY NO.
3. DATE OF BIRTH (MONTH, DAY, YEAR)	4. AGE IN FULL YEARS (IN)

OCCUPATIONAL EXPOSURE—PREVIOUS HISTORY

5. PREVIOUS EMPLOYMENTS INVOLVING RADIATION EXPOSURE—LIST NAME AND ADDRESS OF EMPLOYER	6. DATES OF EMPLOYMENT (FROM—TO)	7. PERIODS OF EXPOSURE	PREVIOUS DOSE HISTORY	
			8. WHOLE BODY (REM)	9. RECORD OR CALCULATED (INSERT ONE)
10. REMARKS		11) ACCUMULATED OCCUPATIONAL DOSE—TOTAL		

13. CALCULATIONS—PERMISSIBLE DOSE

WHOLE BODY:

(A) PERMISSIBLE ACCUMULATED DOSE = 5(N—18) = _____ REM

(B) TOTAL EXPOSURE TO DATE (FROM ITEM 11) = _____ REM

(C) UNUSED PART OF PERMISSIBLE ACCUMULATED DOSE (A—B) = _____ REM

12. CERTIFICATION: I CERTIFY THAT THE EXPOSURE HISTORY LISTED IN COLUMNS 5, 6, AND 7 IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

EMPLOYEE'S SIGNATURE _____ DATE _____

14. NAME OF LICENSEE OR REGISTRANT

KSC

Form PSH—RAD-9
(1-64)

CURRENT OCCUPATIONAL EXTERNAL RADIATION EXPOSURE

See Instructions on the Back

IDENTIFICATION

1. NAME (PRINT—Last, first, and middle)	2. SOCIAL SECURITY NO.
3. DATE OF BIRTH (Month, day, year)	4. NAME OF LICENSEE OR REGISTRANT

OCCUPATIONAL EXPOSURE

5. DOSE RECORDED FOR (Specify: Whole body; skin of whole body; or hands and forearms, feet and ankles.)	6. WHOLE BODY DOSE STATUS (rem)	7. METHOD OF MONITORING (e.g., Film Badge—FB; Pocket Chamber—PC; Calculation—Calc.) X or GAMMA_____ BETA_____ NEUTRONS _____

8. PERIOD OF EXPOSURE (From—to)	DOSE FOR THE PERIOD (rem)				13. RUNNING TOTAL FOR CALENDAR QUARTER (rem)
	9. X OR GAMMA	10. BETA	11. NEUTRON	12. TOTAL	

LIFETIME ACCUMULATED DOSE

14. PREVIOUS TOTAL (rem)	15. TOTAL QUARTERLY DOSE date rem	16. TOTAL ACCUMULATED DOSE (rem)	17. TERM. ACC. DOSE (18—18) (rem)	18. UNUSED PART OF PERMISSIBLE ACCUMULATED DOSE (rem)

KENNEDY SPACE CENTER

Health Physics

REPORT OF RADIATION EXPOSURE

FILM BADGE NO._____

NAME_____ DATE OF REPORT_____

MONTH OF EXPOSURE_____ EXPOSURE (mrem)_____

DUTIES DURING MONTH_____

EXPLANATION FOR EXPOSURE (To be filled in by worker):_____

_____

_____

_____

_____

_____

_____

DATE_____ SIGNED_____

SUPERVISOR: DATE_____ SIGNED_____

HEALTH PHYSICS NOTES AND DISPOSITION:

_____

_____

_____

_____

_____

_____

_____

DATE_____ SIGNED_____

To be filled out in all cases in which film-badge indicates an exposure of greater than 100 millirems.

KSC FORM OT-018 (1/67) (ONETIME ONLY - NOT STOCKED)

Workplace Examinations Input

JSC

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION
Lyndon B. Johnson Space Center
Environmental Health Services

INDUSTRIAL HYGIENE SURVEY REPORT

Office Use
Building
Hazard

1. Facilities Description

Facility: Building No. Room No:

Person Contacted: Telephone:

Operation: Sketch:

2. Hazard Description (Be specific, use additional sheets as necessary)

Type of Hazard:

Personnel Exposed: Total Population at Risk:

Exposure Evaluation:

3. Conclusions and Recommendations:

SURVEYOR: DATE:

LIGHTING SURVEY		DATE:
TO: AB23	THRU: AS01	FROM: AS01M

NAME OF PERSON REQUESTING SURVEY:	PHONE NO.:	NAME OF PERSON PERFORMING SURVEY:

AREA SURVEYED

BUILDING NO.:	ROOM NO.:	TYPE OF OPERATION:

RECOMMENDED FOOTCANDLES FOR THIS OPERATION:

REMARKS BY AS01M:

AREA LAYOUT:

REMARKS BY AS01:

MSFC - Form 8680 (November 1976)

MSFC

LOCAL EXHAUST SYSTEMS SURVEY

Bldg. #.	Room	Type of System	Measured Face Vel. FPM	Required Face Vel. FPM	Type of Work in Area	# Assigned to System

MARSHALL SPACE FLIGHT CENTER

LASER SURVEY

DATE

LOCATION		NAME OF RESPONSIBLE PERSON	ORGANIZATION SYMBOL
BUILDING NO	ROOM		

DESCRIPTION

MANUFACTURER	MODEL NO.	SERIAL NO.	MSFC NO.

POWER OR ENERGY OUTPUT	LASER CLASS	CW OR PULSED	TYPE OF LASER

PERSONNEL PROTECTION

OPTICAL GOGGLES?	MANUFACTURER	MODEL
☐ YES ☐ NO		

OPTICAL DENSITY	WAVELENGTH

☐ YES	☐ NO	SHIELDING	☐ YES	☐ NO	MEDICAL EXAMINATION
☐ YES	☐ NO	NON-REFLECTIVE SURFACES	☐ YES	☐ NO	INTERLOCKING DEVICES
☐ YES	☐ NO	PROPER LIGHTING	☐ YES	☐ NO	COPY OF SOP PRESENT
☐ YES	☐ NO	SHOCK PROTECTION	☐ YES	☐ NO	COPY OF ANSI STD.
☐ YES	☐ NO	WARNING SIGNS AND/OR SIGNALS			

PERSON PERFORMING SURVEY

REMARKS

MSFC - Form 3665 (January 1978)

WALK-THRU SURVEY CHECK LIST

Date_____ Building _____

The following items should be especially noted during a walk-thru survey of buildings at MSFC: (If an item is not applicable to a building, then enter NA under O.K. column.)

Item	Subject	Improvement Needed	O.K.	Recheck by EH
1.	Noise			
2.	Lighting			
3.	Heat			
4.	Ventilation			
5.	Housekeeping and Material Handling			
6.	Personal Protection			
8.	Lasers			
9.	Radiation - Ionizing			
10.	Solvents			
11.	Microwave Ovens			
12.	Beryllium			
13.	Mercury			
14.	Lead			
15.	Asbestos			
16.	Special Operations:			
	a. Welding and Soldering			
	b. Spray Painting			
	c. Plating			
	d. Heavy Equipment			
17.	Other			

KSC

OCCUPATIONAL MEDICINE/ENVIRONMENTAL HEALTH SERVICES
WATER CHEMISTRY ANALYSIS

TYPE EXAMINATION REQUESTED: [ ] KSC [ ] CKAFS

DATE RECEIVED	DATE COMPLETED	EHL LOG NO

SAMPLE LOCATION

PARAMETERS / SAMPLE NO.								
Coliform bacteria (no./100 m								
Total bacteria (no./100 ml)								
Dissolved oxygen (mg/l)								
B.O.D. (mg/l)								
C.O.D. (mg/l)								
Total solids (mg/l)								
Dissolved solids (mg/l)								
Suspended solids (mg/l)								
pH								
Conductivity (μmho/cm)								
Detergents (mg/l)								
Free mineral acids (mg/l)								
Hydrocarbons (mg/l)								
Phenols (mg/l)								
Chloride ion (mg/l)								
Cyanide ion (mg)								
Fluoride ion (mg l)								
Nitrate ion (mg l)								
Phosphate ion (mg·l)								
Sulfate ion (mg l)								
Sulfide ion (mg/l)								
Al (mg/l)								
As (mg/l)								
Ca (mg/l)								
Cr (mg/l)								
Fe (mg/l)								
Hg (mg/l)								
K (mg/l)								
Ni (mg/l)								
Pb (mg/l)								
Zn (mg/l)								

REMARKS

APPROVED BY

KSC [illegible] 70-284 (12/72)

NASA/KSC JAN 73

KSC

OCCUPATIONAL MEDICINE/ENVIRONMENTAL HEALTH SERVICES PROJECT AREAS

MONTHLY SAFETY INSPECTION REPORT - CHECK SHEET

Location: **Date:**

Inspected by:

Accompanied by:

S	U	
X		Satisfactory

S	U	
X		Unsatisfactory Requires Explanation

S	U	
		OFFICES
		(a) Housekeeping
		(b) Proper Lighting
		(c) Floor Conditions
		(d) Fire Hazards
		(e) Tripping Hazards
		(f) Excess Materials
S	U	HALLS
		(a) Walk Ways Open
		(b) Floor Conditions
		(c) Lighting
		(d) Closets
S	U	LABORATORY, BACTERIOLOGICAL
		(a) Housekeeping
		(b) Specimen Disposal
S	U	LABORATORY, CLINICAL
		(a) Housekeeping
		(b) Exhaust Hood
		(c) Specimen Disposal
S	U	LABORATORY, GENERAL CHEMISTRY
		(a) Housekeeping
		(b) Exhaust Hood
		(c) Handling of Chemicals
		(d) Handling of Glassware
		(e) Equipment
S	U	LABORATORY, INSTRUMENTATION
		(a) Housekeeping
		(b) Exhaust Hood
		(c) Equipment

MONTHLY SAFETY INSPECTION REPORT - CHECK SHEET

(con't Page 2)

S	U	LABORATORY - CHEMICAL ANALYSIS
		(a) Housekeeping
		(b) Proper Storage
S	U	STERILIZATION ROOM
		(a) Housekeeping
		(b) Equipment
S	U	MEDICAL SECTION
		(a) Housekeeping
		(b) X-ray
		(c) VAB
		(d) CCAFS
		(e) LCMT
		(f) Emergency Trailer
		(g) Vehicles
		(h) Storage Areas

GENERAL COMMENTS:

Identify Specific Location/Safety Discrepancy

KSC

ENVIRONMENTAL HEALTH

FOOD SERVICE SANITATION CHECKLIST

NAME OF FACILITY INSPECTED	DATE	TIME

ITEM INSPECTED	S	U	ITEM INSPECTED	S	U
1. FOOD SERVICES WORKERS			4. SERVING TECHNIQUE		
A. HEALTH CERTIFICATE			A. SERVING LINE		
B. PERSONAL HYGIENE			B. SANDWICHES		
2. FACILITIES AND EQUIPMENT			C. FROZEN FOOD		
			D. LEFT-OVER FOOD		
A. VENTILATION			5. DISHWASHING TECHNIQUE		
B. FLOOR			A. PRE-WASH		
C. INSECT AND RODENT CONTROL			B. WASH (TEMP.)		
D. UTENSIL STORAGE			C. RINSE (TEMP.)		
E. MOP AND BROOM RACK			D. STORAGE OF CLEAN EQUIPMENT		
F. RESTROOMS			6. FOOD PREPARATION		
G. OUTSIDE AREA			A. EQUIPMENT		
H. GARBAGE DISPOSAL			B. FOOD HANDLING		
3. STORAGE TECHNIQUES			C. FOOD TEMPERATURES		
A. REFRIGERATORS					
B. DRY STORAGE					
C. VEGETABLES					
D. BREAD AND BAKERY PRODUCTS					
E. FOOD HANDLING					

REMARKS AND RECOMMENDATIONS. WRITTEN REPLY IS REQUIRED WITHIN 10 DAYS

C-2

GENERAL RATING		SIGNATURE OF SANITARIAN	SIGNATURE OF FOOD SERVICE SUPERVISOR
SATISFACTORY			
UNSATISFACTORY			

KSC FORM 16-286 (5/71) *S – SATISFACTORY U – UNSATISFACTORY NASA/KSC AUG/75

KSC

AIR MONITORING DATA SHEET

DATE

OPERATING INSTRUCTIONS

1. POSITION THE SAMPLER ABOUT 5 FEET ABOVE GROUND LEVEL IF PRACTICABLE.

2. START THE SAMPLER AFTER INSURING THE FILTER IS NOT PUNCTURED, IS PROPERLY POSITIONED AND THE TOP RING IS SECURED TIGHT ON THE SAMPLER.

3. FILL IN THE BLANKS BELOW AS INDICATED:

A. TEAM NUMBER	LOCATION	SAMPLER TYPE

S/N	FILTER SIZE	SURVEY METER TYPE	S/N

B. BACKGROUND DATA

	TIME	FLOW RATE	SURVEY METER READING
START			
STOP			

C. AIR ACTIVITY DATA

TIME	FLOW RATE	SURVEY METER READING

KSC

ENVIRONMENTAL HEALTH MICROWAVE OVEN SURVEY

LOCATION	DATE	READING mW/cm²	SATISFACTORY	UNSATISFACTORY

REMARKS AND/OR RECOMMENDATIONS:

Sanitarian

FSC

HEALTH PHYSICS RADIATION SURVEY RECORD

DATE:_____ PROJECT NO:_____ USER:_____ RSO:_____

LOCATION:_____ _____ _____ _____ _____
USE AREA/STORAGE | BLDG. NO. | ROOM | CUSTODIAN/SUPV'R | AUTHORIZATION

RADIATION SOURCES:

DESCRIPTION:	ISOTOPE:	APPROX. ACT:	FORM:

SPECIAL MONITORING REQUIREMENTS: _____

MAX. AREA DOSE RATE (GENERAL WORK AREA/BOUNDARY)

SOURCE SHIELDED _____
SOURCE UNSHIELDED _____

AREA WIPE TEST CONDUCTED:_____

RESULTS:_____

RADIOLOGICAL CONTROL SECTION

AREA CLASSIFICATION & ACCESS CONTROLS: _____

POSTING REQUIREMENTS:	YES	NO	N/A	REMARKS
WARNING SIGNS				
NOTICE TO EMPLOYEES				
RULES & REGS.				
LICENSE COPY				
OPERATING PROCEDURES				
KHB & KMI 1860.1/IS				
EMERGENCY PROCEDURES				
10 CFR 19 & 20				
AFETRM 160-1 & 160-2				
"ON FILE" LIST				

HEALTH PHYSICS RADIATION SURVEY RECORD
(CONTINUED)

PERSONNEL MONITORING REQUIREMENTS:	YES	NO	N/A	REMARKS
BADGES	____	____	____	_____
DOSIMETERS	____	____	____	_____
OTHER	____	____	____	_____
CONTAMINATION CONTROL	____	____	____	_____
SHIELDING/SPECIAL HANDLING REQUIREMENTS:	____	____	____	_____

NOTES: _____

CONCLUSION: _____

COMMENTS: _____

PREPARED BY: _____

PAN AM HEALTH PHYSICS

KSC

RADIOGRAPHY SURVEY

DATE:	TIME:	LOCATION:

DESCRIPTION OF OPERATION:	RADIOGRAPHER:

RADIATION SOURCES

NUCLIDE:	S/N:	ACTIVITY:

CAMERA READING: _____ MR/HR	DISTANCE:

CAMERA TYPE:

☐ < 4 INCHES FROM SOURCE TO EXTERIOR SURFACE

☐ MINIMUM 4 INCHES FROM SOURCE TO EXTERIOR SURFACE

RADIATION PRODUCING DEVICE:	KV:	MA:

LEAK TEST CERTIFICATE: ☐ YES ☐ NO	DATE:

SURVEY INSTRUMENTATION

INSTRUMENT:	DATE CALIBRATED:	2 MR/HR – 1 R/HR CAPABILITY: ☐ YES ☐ NO

PERSONNEL MONITORING CONTROL

FILM BADGES: ☐ YES ☐ NO	PAIRED POCKET CHAMBERS/DOSIMETERS: ☐ YES ☐ NO

RADIOGRAPHIC OPERATIONS

BARRIERS:

CONTINUOUS RESTRAINING BARRIER: ☐ YES ☐ NO

DESCRIPTION: _____

_____

_____

POSTING REQUIREMENTS:

"CAUTION RADIATION AREA" SIGNS AT 2 MR/HR: ☐ YES ☐ NO

"CAUTION HIGH RADIATION AREA" SIGNS AT 100 MR/HR: ☐ YES ☐ NO

"RADIOACTIVE" SIGNS ON VEHICLES: ☐ YES ☐ NO ☐ N/A

NIGHT OPERATIONAL REQUIREMENTS (If Applicable):

AMBER/WHITE LIGHTS FOR ILLUMINATION OF SIGNS: ☐ YES ☐ NO

FLASHING RED LIGHTS USED FOR WARNING: ☐ YES ☐ NO

RADIOGRAPHY SURVEY (Continued)

DATE:	OPERATION:

RADIOGRAPHIC OPERATIONS (Continued)

SECURITY AGAINST UNAUTHORIZED EXPOSURE:

CONSTANT SURVEILLANCE BY RADIOGRAPHER/ASSISTANT:	☐ YES	☐ NO	☐ N/A
CONTROL DEVICE/ALARM SYSTEM UTILIZED:	☐ YES	☐ NO	☐ N/A
AREA LOCKED TO PREVENT UNAUTHORIZED ENTRY:	☐ YES	☐ NO	☐ N/A

SURVEYS:

SURVEY(S) TO ENSURE 2 MR/HR BOUNDARY:	☐ YES	☐ NO
SURVEY(S) TO ENSURE SOURCE RETURNED TO SHIELDED POSITION:	☐ YES	☐ NO

COMMENTS

PREPARED BY: _____
OMEHS

GODDARD SPACE FLIGHT CENTER

HEALTH PHYSICS ACTIVITY REPORT

PAGE _____ OF _____

DATE: _____

BLDG: _____

ROOM: _____

CUSTODIAN: _____

TYPES OF EMITTER:

TYPE OF JOB: AREA SURVEYS ☐ ROUTINE ☐ NON-ROUTINE

THERMAL VACUUM RESULTS ☐

SOURCE LEAK TESTS ☐ QUARTERLY INVENTORY ☐ INTRA TRANSFERS ☐ IRRADIATORS

COMMENTS: _____

THERMAL VACUUM

SOURCE NUMBERS:	ACTIVITY:	DATE:

CHAMBER NO. _____

PROGRAM _____

DATE INTO CHAMBER _____

DATE OUT CHAMBER _____

SOURCE(S) QUALIFIED ☐ YES ☐ NO

TEST CONDUCTOR

SOURCE USE: INTERNAL ☐ EXTERNAL ☐

TV PARAMETERS:

_____ °C _____ TORR _____ HRS.

_____ °C _____ TORR _____ HRS.

INSTRUMENTS USED (USE CODE)

PORTABLE

CODE	IDENTIFICATION TYPE	IDENTIFICATION MODEL	IDENTIFICATION SER. NO.	TYPE RAD'N	BACKGROUND RDG	BACKGROUND UNITS
A						
B						
C						
D						

LABORATORY

CODE	MDA CPM	MDA DPM	SERIAL NO.	TYPE RAD'N	BACKGROUND	TIME	% EFFICIENCY
J							
K							
L							
M							
N							
O							

DOSE RATE MEASUREMENTS

POINT MEASURED	CODE	DISTANCE	READING

LABORATORY RESULTS OF RADIOACTIVITY SAMPLES

COUNTED BY: DATE:

LINE NO.	DESCRIPTION OF SAMPLE	CODE	TOTAL COUNTS	ΔT MIN	GROSS CPM	BKGD CPM	NET CPM	DPM/100CM²	MICROCURIES
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									

REMARKS: _____

BACKGROUND AUTO. SUBT. ☐

REVIEWED BY _____ DATE: _____

CONCURRED BY _____ DATE: _____

ACTION REQUIRED

FILE COPY: ☐

OTHER: _____

ACTION TAKEN

BY: _____

DATE: _____

GSFC 23-27 (10/70)

White – Health & Safety Engineering Office; Pink – Custodian or other

Environmental Agent Records Input

JSC

MMH
(Monomethyl Hydrazine)

3	High Health Hazard
3	Highly Flammable
2	Moderately Reactive

MATERIAL SAFETY DATA SHEET

I PRODUCT IDENTIFICATION

MANUFACTUREP'S NAME	REGULAR TELEPHONE NO EMERGENCY TELEPHONE NO
ADDRESS	
TRADE NAME	
SYNONYMS Monomethyl hydrazine, 1-methylhydrazine, CH_3NHNH_2	

II HAZARDOUS INGREDIENTS

MATERIAL OR COMPONENT	%	HAZARD DATA
.MMH (Monomethyl Hydrazine)	> 99	LD50: 80 mg/kg (Orl - rat)
Water	< 1	
—		

III PHYSICAL DATA

BOILING POINT, 760 MM HG	-62.3° F.	MELTING POINT	< -112° F.
SPECIFIC GRAVITY (H_2O=1)	1.59	VAPOR PRESSURE	80° F. @ 56 mm
VAPOR DENSITY (AIR=1)	1.6	SOLUBILITY IN H_2O, % BY WT	Soluble
% VOLATILES BY VOL	100	EVAPORATION RATE (BUTYL ACETATE = 1)	---
APPEARANCE AND ODOR	Clean liquid with ammonia-like odor.		

IV FIRE AND EXPLOSION DATA

FLASH POINT (TEST METHOD)	17° F. (Closed Cup)		AUTOIGNITION TEMPERATURE	382° F.	
FLAMMABLE LIMITS IN AIR, % BY VOL		LOWER	2.5	UPPER	98
EXTINGUISHING MEDIA	Water, foam, dry chemical and carbon dioxide.				
SPECIAL FIRE FIGHTING PROCEDURES	In advanced or massive fires, fire fighting should be done from a safe distance or from a protected location; use water to keep fire-exposed containers cool.				
UNUSUAL FIRE AND EXPLOSION HAZARD	Vapor forms explosive mixture, with air over a wide range.				

V HEALTH HAZARD INFORMATION

HEALTH HAZARD DATA: OSHA standard is 0.1 parts per million (ppm).

ROUTES OF EXPOSURE

INHALATION	Local and systemic effects in respiratory system.
SKIN CONTACT	Corrosive to skin.
SKIN ABSORPTION	Can penetrate skin to cause systemic toxicity.
EYE CONTACT	Liquid contact may cause eye burns or blisters.
INGESTION	Systemic toxicity.

EFFECTS OF OVEREXPOSURE

ACUTE OVEREXPOSURE	Irritation, central nervous system depression, skin burns, dizziness, loss of weight, cardiovascular collapse, convulsio
CHRONIC OVEREXPOSURE	Damage to liver, kidney; anemia; hemolysis of red blood cells.

EMERGENCY AND FIRST AID PROCEDURES

EYES	Irrigate with water.
SKIN	Wash with soap and water.
INHALATION	Call a physician as soon as possible.
INGESTION	Call a physician as soon as possible.

NOTES TO PHYSICIAN: Treat burns as usual. Gastric lavage, if ingested, followed by saline catharsis. Pyridoxine Hydrochloride, in high doses by injection, has been used. Sedation, if necessary. Symptomatic and supportive.
DIAGNOSTIC TESTS: Anemia
Isonicotinic acid hydrazine may be found in blood plasma.

VI REACTIVITY DATA

CONDITIONS CONTRIBUTING TO INSTABILITY Free air, oxidizer, electrical sparks and heat source.

INCOMPATIBILITY Compatible with most common metals.

HAZARDOUS DECOMPOSITION PRODUCTS

Nitrogen compounds.

CONDITIONS CONTRIBUTING TO HAZARDOUS POLYMERIZATION

None.

VII SPILL OR LEAK PROCEDURES

STEPS TO BE TAKEN IF MATERIAL IS RELEASED OR SPILLED

Large quantities may be burned under supervision.

Small quantities may be flushed.

NEUTRALIZING CHEMICALS

None.

WASTE DISPOSAL METHOD Incineration, biological oxidation.

VIII SPECIAL PROTECTION INFORMATION

VENTILATION REQUIREMENTS Local exhaust ventilation.

SPECIFIC PERSONAL PROTECTIVE EQUIPMENT

RESPIRATORY (SPECIFY IN DETAIL) Self-contained respirator.

EYE Face shield.

GLOVES Fuel-resistant vinyl-coated gloves.

OTHER CLOTHING AND EQUIPMENT Acid suit.
Rubber safety shoes.

IX SPECIAL PRECAUTIONS

PRECAUTIONARY STATEMENTS

Separate from oxidizing materials.

Extremely harmful if inhaled, swallowed or absorbed through the skin.

Corrosive to skin.

A suspect carcinogen.

OTHER HANDLING AND STORAGE REQUIREMENTS

Outside or detached storage if preferred. Inside storage should be in a standard flammable liquid storage room or cabinet. Tanks should be located in water-filled dikes.

A nitrogen atmosphere should be maintained over anhydrous hydrazine.

PREPARED BY [redacted]

ADDRESS Environmental Health Services/SD13

DATE 19 January 1977

ARL

RADIATION SAFETY COMMITTEE LASER INVENTORY

HP# ____

ORG. _____ AUTHORIZED LASER USER _____

BLDG. _____ ROOM NO. _____ DATE _____ CLASS _____

1. DESCRIPTION OF LASER

   A. TYPE _____ E. WAVE LENGTH EMITTED _____

   B. MANUFACTURER _____ F. MAXIMUM OUTPUT _____

   C. MODEL/SERIAL _____ G. BEAM DIAMETER _____

   D. ARC # _____ H. BEAM DIVERGENCE _____

2. OTHER USERS OF LASER _____

3. DESCRIPTION OF USE _____

4. SAFETY FEATURES

   A. SHIELDING _____

   B. WARNING DEVICES _____

   C. INTERLOCKS _____

   D. SPECIAL OPERATING PROCEDURES _____

   E. CLASSIFICATION LABEL _____

5. EYE PROTECTION

   A. TYPE OF EYEWEAR _____

   B. WAVE LENGTH MARKED ON EYEWEAR _____

   C. OPTICAL DENSITY (OD) _____

   D. SPECIAL PROVISIONS _____

6. SPECIAL HAZARDS _____

DATE _____ _____

SIGNATURE OF PERSON RESPONSIBLE FOR LASER

DATE _____ _____

RADIATION SAFETY OFFICER

DSS 27 (Rev. 1-77)

AKC

RADIOISOTOPE INVENTORY RECORD

AUTHORIZED USER _____ ISOTOPE _____

CHEMICAL FORM	SUPPLIER/LOT NO.	ACTIVITY		RECEIVAL DATE	DISPOSAL DATE
		MILLICURIES (m Ci)	MICROCURIES (μ Ci)		

DSS-24
(APR 73)

Action Items Input

GSFC

REQUEST FOR RADIATION SAFETY COMMITTEE REVIEW - LASER

DATE:
CODE:
INITIATOR:
BLDG:_____ ROOM_____
LASER PRINCIPAL OPERATOR:
TYPE OF LASER: MEDIUM_____
MODE: Q SWITCHED_____
NON Q SWITCH_____
C W _____
LASER MANUFACTURER:_____
MODEL:_____ SERIAL NUMBER_____
USE OF LASER_____
_____
_____

OUTPUT PERAMETERS:

1. ENERGY/POWER:_____
2. PULSE REPETITION RATE:_____Hz
3. MAX POWER OUTPUT_____
   AV POWER OUTPUT_____
4. PULSE DURATION_____
5. EMERGENT BEAM DIAM_____cm
6. WAVELENGTH(s)_____
7. EMERGENT BEAM DIVERGENCE_____mrad

WHAT LOCATION IS LASER TO BE USED?

PERSONS WHO WILL USE LASER:

PROCEDURES:

CONTROLS:

INDIVIDUAL RESPONSIBLE FOR CONTROL AND ACCOUNTABILITY:

REVIEWED AND APPROVED (BRANCH HEAD OR OTHERWISE AS APPROPRIATE)

_____ _____
NAME DATE

☐ APPROVED ☐ DISAPPROVED
☐ APPROVED SUBJECT TO ATTACHED REQUIREMENTS

_____ _____
RSO OR CHAIRMAN DATE

KSC

RADIOACTIVE MATERIAL USE REQUEST

(Prepare in original and four copies)

FROM (NAME) *(Please print)*	OFFICE CODE	DATE	REF. NUMBER *

TO: KSC RADIATION PROTECTION OFFICER (RPO)
VIA
HEALTH PHYSICS SECTION (OMEHS)

1. RADIOACTIVITY REQUIREMENTS

A. ELEMENT AND ISOTOPE	B. PHYSICAL FORM

C. TOTAL QUANTITY REQUIRED (MC OR UNITS)	D. ESTIMATED ACTIVITY PER EXPERIMENT (MC OR UNITS)

E. WASTE CONCENTRATIONS & AMOUNTS	LIQUID	SOLID

2. TITLE OR BRIEF DESCRIPTION OF PROPOSED PROJECT

3. PROPOSED PROCEDURE (INCLUDING SPECIAL PRECAUTIONS)

	3A. LICENSE NO.	3B. NRC ☐ STATE OF

4. LOCATION OF USE	BUILDING NUMBER	ROOM NUMBER	AREA ZONE NUMBER

5. USERS	6. PERIOD COVERED BY REQUEST
	FROM _____ TO _____

7. HEALTH PHYSICS EQUIPMENT REQUIREMENTS

ORIGINATOR	SUPERVISOR'S SIGNATURE

APPROVALS

SIGNATURE (OMEHS HEALTH PHYSICS)	DATE

SIGNATURE (KSC RADIATION PROTECTION OFFICER)	DATE

SIGNATURE (CHAIRMAN RSC)	DATE

ORIGINAL – RSC COMMITTEE COPY 2 KSC RPO COPY 1 HEALTH PHYSICS

* *Supplied by Health Physics Section.*

KSC FORM 16-209NS (REV. 8/77)

KSC.

LASER USE EVALUATION	ENVIRONMENTAL HEALTH REQUIREMENTS FOR LASER OPERATIONS (KHB 1840.1)

NAME OF USE REQUESTER	ORGANIZATION	DATE	REF. NUMBER *

A. SYSTEM DESCRIPTION

1 MANUFACTURER	2 MODEL	3 SERIAL NO

4 TYPE (CW OR PULSED)	5 PULSE WIDTH	6 PULSE REPETITION RATE	7 WAVELENGTH

8 TOTAL OUTPUT (POWER OR ENERGY)	9. BEAM DIAMETER (EXIT)	10 BEAM DIVERGENCE

11 LOCATION OF USE

B. TITLE OR BRIEF DESCRIPTION OF PROPOSED USE

C. PROPOSED PROCEDURES (INCLUDING SPECIAL PRECAUTIONS)

D. ENVIRONMENTAL HEALTH REQUIREMENTS

1. SAFE EYE EXPOSURE DISTANCE (SEED) DAY: NIGHT:	2. MINIMUM OPTICAL DENSITY OF LASER SAFETY GLASSES (OD)

3. OTHER

4. OMEHS SIGNATURE	5. DATE

6. ENVIRONMENTAL HEALTH APPROVAL (SIGNATURE)	7. DATE

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*SUPPLIED BY OMEHS

GODDARD SPACE FLIGHT CENTER

SAFETY REPORT

Safety Report No:

Date Received:

1. Type of report	Code	Date and Time	Yr.	Mo.	Day	Hr.	Mn.	3. Place	Facility Number	Room

4. Person Involved	Social Security Number	Sex	Age	Type	Occupation	Organization

5. Activity Engaged In		6. Type of Incident	
7. Agency Involved (What was used, done, etc.)		8. Result of Incident	
9. Nature of Injury/Illness		10. Part of Body Affected	
11. Severity of Injury/Illness		12. Human Factor	
13. Physical/Environmental Factor		14. Report Sent to OWCP?	Y N

15. Action(s) Taken	19. Lost Time Data	Mo.	Day	Yr.
	a. Date unable to perform regular established duties			
	b. Date returned to work (Regularly established duties)			
16. Professional Effort(s)	c. Date returned to work (Restricted work activities)			
	d. Date terminated			
17. Disposition	e. Date permanently transferred to lighter duty			
18. Property Involved	f. Number of days of restricted activity			
Description / Type / Own / Amount of Loss	g. Number of days lost			
$ 0 0	h.			
$ 0 0	i.			
$ 0 0				

Narrative (Include who, what, when, where, and how)

Continue on separate sheet, if necessary

Corrective Action Taken or Planned

When: Now _____ or FY _____

Prepared By:	Signature:	Name:	Code:	Date: