



## 7. PHYSICAL ACTIVITY OR EXERCISE PROGRAM

Describe your physical activity or exercise program:

Aerobic exercise:  Low  Moderate  High  
Activities: \_\_\_\_\_  
Frequency: \_\_\_\_\_ (days per week)  
Duration: \_\_\_\_\_ (minutes/session)

Isometric exercise:  Low  Moderate  High  
Activities: \_\_\_\_\_  
Frequency: \_\_\_\_\_ (days per week)  
Duration: \_\_\_\_\_ (minutes/session)

## 8. HEARING QUESTIONNAIRE

	Yes	No
Have you had prior military service?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had previous ear surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had recurrent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a known hearing loss?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a recent cold or congestion?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had noise exposure within the last 14 hrs?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear hearing protection?	<input type="checkbox"/>	<input type="checkbox"/>

If "yes", type:  foam  pre-molds/plugs  ear muffs

## 9. REVIEW OF SYSTEMS - Which of the following have been a problem for you *in the last year?*

### General/Constitutional

- Fever, >100°
- Shivering/ chills
- Generalized weakness
- Unexplained weight loss/gain
- Excessive fatigue
- Swollen glands
- Loss of appetite

### Eyes

- Change in vision
- Itching
- Tearing

### Ears, Nose, Throat

- Difficulty hearing
- Ringing, buzzing
- Sinus trouble
- Sneezing/runny nose
- Nosebleeds
- Difficulty swallowing

### Heart/Lungs

- Chest pain or pressure
- Irregular heart beat
- Palpitations/skipped beats
- New or changed cough
- Coughing up blood
- Wheezing
- Shortness of breath

### Digestive System

- Nausea/vomiting
- Diarrhea/constipation (*circle one or both*)
- Yellow jaundice
- Rectal bleeding or black tarry stools

### Neurologic/Psychiatric

- Headaches
- Dizziness/passing out (*circle one or both*)
- Depression
- Numbness or tingling
- Excessive anxiety
- Insomnia/difficulty sleeping
- Loss of memory

### Skin/Musculoskeletal

- Rashes
- Moles that changed in size or color
- Muscle pain
- Back pain
- Neck pain
- Weakness in arms/legs
- Joint pain

### Genitourinary & Reproductive

- Difficult or painful urination
- Blood in urine
- Difficulty having children

### (Men Only)

- Lump in Testicle
- Impotence

### (Women Only)

- Irregular periods/spotting
- Miscarriage or stillborn pregnancy
- Breast lump/discharge
- Currently or possibly pregnant

**Examiner's comments:** [All positive responses by employee on pages 1-2 should be clarified.]

**NOTE: PAGES 4 AND 5 ARE TO BE COMPLETED BY EXAMINING PHYSICIAN**



**MEDICAL SURVEILLANCE PROGRAM**  
**III. Summary**

**12. ASSESSMENT / REFERRAL PLAN:**

	Comments:	Not Referred	--Referred-- Routine	Urgent
1. _____	_____	[ ]	[ ]	[ ]
2. _____	_____	[ ]	[ ]	[ ]
3. _____	_____	[ ]	[ ]	[ ]
4. _____	_____	[ ]	[ ]	[ ]
5. _____	_____	[ ]	[ ]	[ ]

\_\_\_\_\_  
 Examiner (print)

\_\_\_\_\_  
 Examiner's signature

\_\_\_\_\_  
 Date

I have received a copy of the summary of my examination and understand the recommendations:

\_\_\_\_\_  
 Employee's Signature

\_\_\_\_\_  
 Date