

TRANSPORTATION SECURITY OFFICER **MEDICAL QUESTIONNAIRE**

PRIVACY ACT AND PAPERWORK REDUCTION ACT STATEMENTS

The Transportation Security Administration (TSA) requires physical/medical examinations prior to an individual's appointment to a TSA Security Officer (Screener) position. FSA uses the following medical documents to obtain information relevant to an applicant's health status for purposes of making an employment decision. This is a mandatory collection of information if you wish to be considered for a TSA Security Officer (Screener) position. It is estimated that the total average burden per response associated with this collection is approximately 18 minutes. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The control number assigned to this collection is OMB 1652-0032, which expires 09/08.

Failure to submit to the examination or failure to make full and open disclosure of any current or past medical conditions, including incomplete, misleading or inaccurate information, may be grounds for disqualification from TSA employment, or disciplinary or adverse action if employed.

49 U.S.C. § 114 (e) authorizes the collection of this information. TSA will not disclose this information other than for routine uses as identified in OPM system of records, OPM/GOVT-10 if hired, or OPM/GOVT-5 if not hired. Upon written authorization from the individual, the agency may release a copy of the medical record. The individual should forward a notarized letter to the agency identifying to whom the information may be released. Disclosure of your SSN is voluntary. This information is used to identify and separate individuals with similar or identical names or initials. If you do not provide your SSN or any other information requested, we cannot process your application.

INSTRUCTIONS

	DEMOGRAPHIC IN	IFORMATION
Name (Print): Address:		Social Security #:
Home Phone #: Work Phone #: Other Phone #: Best Time to Call:		Date of Birth:/
	GENERAL INFO	PRMATION
1	. Have you been refused employment, dismissed from a job, o stay in school due to any medical condition or excessive abs If yes, please list each medical condition and record the yea	enteeism?
2	. Have you ever been diagnosed or treated for a mental health If yes, specify the year for each mental health condition and	
3	. Have you had, or have you been advised to have, any opera If yes, describe what type of operation and indicate date if a	
4	. Have you been treated at any type of hospital in the last 10 y	ears? 4. Yes No _
5	Have you ever had any illness, injury, or condition (including disability, attention deficit disorder, etc.) other than those alre	• — — — — — — — — — — — — — — — — — — —

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GENERAL INFORMATION (continued)											
	6. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past year for anything other than minor illnesses? If yes, provide an explanation and the name of doctor consulted and/or the hospital/clinic 7. Have you ever been rejected for military service or law enforcement position(s) because of physical, mental, or other medical reasons? If yes, give date and reason for rejection:										
	8.	8. Have you ever been discharged from military service or a law 8. Yes No enforcement position because of physical, mental, or other reasons? If yes, give date and reason. If military discharge, list type (e.g., honorable, other than honorable, for unfitness, unsuital								bility):	
	9.	work related	d injury or il aplete the ch	d a pension or compens Iness? nart below for each occu		sability or	9.	Yes	No	·	
		Disability	Year Disability Granted	Disability related to which Check one.	body system?	% Disability Granted			of Disability /Months)	Is disability permanent? (Yes/No)	
		1		Musculoskeletal Mental Health Other							
		2		Musculoskeletal Mental Health Other							
		3		Musculoskeletal Mental Health Other							
		Are you tak	ing any pre	iver's license? scription medications? prescription medications	s and check t	he box that b	11.	Yes Yes describes ho	No	ake each medicati	on
		-		ne of Medication		Daily		Weekly	-	hly or Less	
VISION:	1.	Do you have	e a total loss	s of vision in your right eye	e?		1.	Yes	No		
				s of vision in your left eye?				Yes			
	3.	Have you ha		of eye surgery (such as L ast year?	asik,		3.	Yes	No		

MEDICAL HISTORY								
HEARING:								
HEARING.	1. Do you have a total loss of hearing in your right ear?	1.	١. ١	Yes	No	Don't Know		
	2. Do you have a total loss of hearing in your left ear?	2.	2. 1	Yes	No	Don't Know		
	3. Do you wear hearing aids? If yes, is it a CROS style hearing aid?	3.			No <i>No</i>	Don't Know		
CARDIOVASC	ULAR: Have you <u>EVER</u> had or experienced any	of the following?						
	1. Chest pains	1.	١. ١	Yes	No			
	If yes, has your doctor prescribed heart medication for				No			
	2. Palpitations (rapid or skipped heart beat)	2.			No	Don't Know		
	If yes, are you receiving treatment?							
	3. Heart murmur If yes, has anyone ever recommended heart valve replace.		3. `	Yes Yes	No <i>N</i> o	Don't Know		
	Heart valve replacement	4.		Yes				
	5. Past history or diagnosis of heart disease	5.	5. `	Yes	No			
	6. Coronary bypass surgery or other heart surgery	6	S. '	Yes	No			
	7. Heart attack or stroke	7.	7. `	Yes	No			
	8. Abnormal EKG or stress test result			Yes				
	Pacemaker or implanted defibrillator			Yes				
	a. Pacemaker? b. Implanted defibrillator?			Yes Yes	No			
	10. High blood pressure					Don't Know		
	11. Circulatory problems (e.g., Raynaud's disease, swelling	of ankles, leg						
	pains, numbness in feet or hands)	11.	۱. ۱	Yes	No	Don't Know		
	12. Cramps in legs	12.	2. '	Yes	No			
	13. Phlebitis or blood clots	13.	3. '	Yes	No	Don't Know		
RESPIRATOR	Y: Have you <u>EVER</u> had or experienced any	of the following?						
	1. Problems breathing, wheezing, persistent cough or short	tness of breath 1.		Yes				
	2. Bronchitis	2.			long ago? No	Don't Know		
			ı	<i>If yes</i> , how	long ago?			
	Blood in sputum or when coughing	3.				Don't Know		
	4. Past history or diagnosis of lung disease	4.	۱. ۱	Yes	No			
	5. History of tuberculosis	5.	5. '	Yes	No			
	0 D W TD	•						
	6. Positive TB test	6.			No long ago?			
	7. Asthma	7.	'. '	Yes	No	Don't Know		
				if yes, now	long ago?			
GASTROINTESTINAL: Have you <u>EVER</u> had or experienced any of the following?								
	1. Persistent stomach or abdominal pain	1.	١. ١	Yes	No			
	Persistent diarrhea or constipation	2		<i>If yes</i> , how Yes				
			1	If yes, how	long ago?			
	3. Blood in stool	3.				Don't Know		
HEPATIC:	Havo you EVED had an averagionas de serv	of the followings		•				
HEPAIIC:	Have you <u>EVER</u> had or experienced any	or the following?						
	1. Liver disease, jaundice or history of cirrhosis	1.				Don't Know		
	2. Hepatitis	2.	. '	rryes, now Yes	long ago? No	Don't Know		

XELETAL / ORTHOPEDIC: Have you EVER had or experienced any of the following?	
2. Any other amputation (e.g., leg, finger, toe) 3. Back pain a. How often do you experience it? b. How often do you take medication for your pain? b. How often do you take medication for your pain? b. Frequently Occasionally Decasionally	
3. Back pain a. How often do you experience it? b. How often do you take medication for your pain? 4. Back surgery 5. Back injury 6. Joint pain or swelling 7. Loss of joint or limb movement 8. Loss of sirength or muscle weakness 9. Difficulty walking 10. Difficulty bending, stooping or squatting 11. Difficulty reaching overhead, moving arms in all directions at shoulders 11. Difficulty reaching overhead, moving arms in all directions at shoulders 11. Yes No 12. Arthritis, rheumatism, bursitis or gout 13. Bone, joint, or other deformity 14. Foot problems (aching, pain when walking in bare feet) 15. Any orthopedic surgery within the past two years 16. Any neck (cervical spine) surgery 17. Any neck (cervical spine) surgery 18. Any fracture(s) with symptoms and/or abnormal range of motion 19. Plate, pin, or rod in any bone 20. Check the statement below that best describes how long you can sit continuously without standing or walking: I am physically able to sit continuously without taking a break for a total of: Less than 1 hour in an 8-hour workday	
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19. Plate, pin, or rod in any bone 19. Yes No 20. Check the statement below that best describes how long you can sit continuously without standing or walking: I am physically able to sit continuously without taking a break for a total of: Less than 1 hour in an 8-hour workday At least 1 to 2 hours in an 8-hour workday At least 3 to 4 hours in an 8-hour workday At least 5 to 6 hours in an 8-hour workday At least 5 to 6 hours in an 8-hour workday At least 1 to 2 hours in an 8-hour workday At least 1 to 2 hours in an 8-hour workday At least 1 to 2 hours in an 8-hour workday At least 3 to 4 hours in an 8-hour workday At least 5 to 6 hours in an 8-hour workday At least 5 to 6 hours in an 8-hour workday At least 5 to 6 hours in an 8-hour workday At least 5 to 6 hours in an 8-hour workday At least 5 to 6 hours in an 8-hour workday At least 5 to 6 hours in an 8-hour workday At least 5 to 6 hours in an 8-hour workday At least 6 to 6 hours in an 8-hour workday At least 7 to 8 hours in an 8-hour workday At least 9 to 9 hours in an 8-hour workday	
20. Check the statement below that best describes how long you can sit continuously without standing or walking: I am physically able to sit continuously without taking a break for a total of: Less than 1 hour in an 8-hour workday	ow
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At least 5 to 6 hours in an 8-hour workday 22. Do you have any lifting restrictions? If yes, what is the maximum weight you are allowed to lift? 23. Place a check next to the response that best describe how often you lift and/or carry objects for each weight cate Lift and/or carry (including upward pulling) a maximum of: Weight Never / Rarely Occasionally 1 to 2 times per month Once per week or more 30 pounds Never or Rarely Occasionally Frequently Trequently Frequently Occasionally Frequently Trequently Occasionally Frequently Trequently Trequently Frequently Trequently Trequently	Ü
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Weight Never / Rarely 0 to 2 times per year Occasionally 1 to 2 times per month Frequently Once per week or more 30 pounds Never or Rarely	gory.
30 pounds Never or Rarely Occasionally Frequently 50 pounds Never or Rarely Occasionally Frequently	
50 pounds Never or Rarely Occasionally Frequently	
,	
24. How often do you participate in each of the following activities?	
Weight Never / Rarely Occasionally Frequently 0 to 2 times per year 1 to 2 times per month Once per week or more	
Climb (Stairs) Never or Rarely Occasionally Frequently	
Stoop/Bend/Squat Never or Rarely Occasionally Frequently	
Kneel Never or Rarely Occasionally Frequently	
25. If you have a limitation performing any of the tasks listed below, place a check in the box (right, left) that corresponds to the side of	
your body with the limitation. Otherwise, check "No Limitations". Limitations No	
a. Can handle or pick up objects from a table with fingers	
b. Can feel objects with fingers and hands (sensation)	tions
c. Can touch finger tips to palm to make a fist	

MEDICAL HISTORY (continued)								
ENDOCRINE:	Have you <u>EVER</u> had or experienced any of the following? 1. Diabetes		V	N.	Doub Know			
			Yes	No	Don't Know Don't Know			
	•		Yes	No	Don't Know			
	4. Blood disorder				Don't Know			
						-		
NEUROLOGIC								
		1.	Yes					
	legs, or feet							
	2. Seizures	2.			Don't Know	-		
	0.7	_	If yes, how	long ago?				
	3. Tremors or shakiness	პ.	fres	NO	Don't Know	-		
	4. Fainting or dizziness	4	Yes	No				
	4. I diffully of dizzilloss	٦.	If ves. how	long ago?				
	5. Head injury	5.	Yes	No	Don't Know			
			If yes, how	long ago?		_		
	6. Wear a brace or back support	6.	Yes					
	7. Frequent or severe headaches	7.	Yes					
	9. Nonza injunz	0	If yes, now	long ago?	Don't Know			
	8. Nerve injury	ο.				-		
	9. Paralysis	9.	Yes	No				
		-						
PSYCHOLOGIC	CAL: Have you <u>EVER</u> had or experienced any of the following?							
			Yes	No				
				long ago?				
	2. Episodes of depression	2.	Yes	No	Don't Know	-		
		_						
	Periods of nervousness or anxiety	3.	Yes	No	Don't Know	-		
	Prescribed medication for a mental health condition	1			Don't Know			
	4. Frescribed medication for a mental health condition	4.		long ago?		-		
	5. History of alcoholism or alcohol use	5.			Don't Know			
	•		If yes, how	long ago?		-		
	6. History of substance or drug use	6.			Don't Know	-		
		_						
	7. Suicide attempt or plans	7.	Yes					
			If yes, now	iong ago?				
	GENERAL HISTORY							
	Answer the following questions:							
	Have you had an organ transplant?	1.	Yes	No				
	2. Are you currently using, or have you in the past used, any narcotic	2.	Yes	No				
	medication or other prescription painkiller?							
	3. Are you currently using, or have you in the past used, sedating medication or tranquilizers?	3.	Yes	No	Don't Know	-		
		4.	Yes	No	Don't Know			
			Yes			-		
	b. Date of repair?							
	5. Do you have any skin problems/disease (e.g., urticaria, eczema,	5.	Yes	No	Don't Know			
	dermatitis, psoriasis)?	_						
		6.	Yes	No				
	a. Type of cancer?							
	b. Date of diagnosis?							
	c. Date of last treatment?							
					Don't Know	-		
	8. Do you use tobacco?	8.	Yes	NO				

GENERAL HISTORY (continued)								
9. Check the statement below that best describes your ability to lift and carry: I affirm that I am physically able to pick up and carry a distance of 25 feet (for example, the distance to cross a two-lane street): 30 lbs. (for example, 2 cases of 12oz. soft drinks 24 cans in each case) 50 lbs. (for example, 3 cases of 12oz. soft drinks 24 cans in each case) 70 lbs. (for example, 4 cases of 12oz. soft drinks 24 cans in each case)								
10.	10. What is your present activity level? Check the level of activity listed below that best describes how often you participate in each of the activities:							
	Activity	Frequently Once per week or more						
	Walk 2 miles continuously	Never/Rarely	Occasionally	Frequently				
	Run 2 miles continuously	Never/Rarely	Occasionally	Frequently				
	Weight training	Never/Rarely	Occasionally	Frequently				
	General fitness activities at gym	Never/Rarely	Occasionally	Frequently				
	Basketball	Never/Rarely	Occasionally	Frequently				
	Tennis, racquetball, badminton	Never/Rarely	Occasionally	Frequently				
	Soccer	Never/Rarely	Occasionally	Frequently				
	Gardening	Never/Rarely	Occasionally	Frequently				
	Golf	Never/Rarely	Occasionally	Frequently				
	Winter sports (cross country skiing, downhill skiing, ice skating)	Never/Rarely	Occasionally	Frequently				
	Other (list):	Never/Rarely	Occasionally	Frequently				
I certify that I have reviewed the foregoing information supplied by me and it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics to furnish the Government a complete transcript of my medical record for purposes of processing my application. I have read the privacy statement at the beginning of this questionnaire and understand that falsification of information on Government forms is punishable by fine and/or imprisonment.								
	Sign your name and enter today's date in the space provided below:							
	Candidate Signature			Date (mm/dd/yyyy)				
	Candidate Signature			Date (mm/dd/yyyy)				
		FOR MEDICAL PE	RSONNEL ONLY					
	Print Name:							
	Signature:							
	Medical Personnel Signature		Date (mm/dd/yyyy)					
	Print Name:							
	Medical Personnel Co-Signature (If required)		Date (mm/dd/yyyy)				

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