

Military Sealift Command Mariner Medical Screening Questionnaire

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

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

Date (dd/mmm/yyyy): _____ Full name (Last, First MI): _____

Date of Birth: _____ Last 4 SSN: _____

MSC Position: _____ Height/Weight: _____ / _____

Email: _____ Phone number: _____

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

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

Please select either YES or NO:

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

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

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

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

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

Explanation to ALL “YES” answers:

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

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

_____ **(Initial)**

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

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

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Additional Information and/or Comments:

* Please see SF-600 entry

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

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