

MAINE MARITIME ACADEMY

Castine, Maine

REPORT OF MEDICAL HISTORY

COMPLETE THIS PAGE
PRIOR TO THE PHYSICAL
EXAMINATION

This form will remain with the Medical
Department, Maine Maritime Academy
and will be released only upon the
approval of the student.

LAST NAME (<i>Print</i>)	FIRST NAME	MIDDLE	AGE	DATE OF BIRTH
HOME ADDRESS (Number and Street)		CITY OR TOWN	STATE	ZIP CODE
NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN				HOME TELEPHONE NUMBER
NEXT OF KIN'S BUSINESS ADDRESS			BUSINESS TELEPHONE	
ARE YOU (THE STUDENT) A VETERAN?		BRANCH AND LENGTH OF SERVICE		MARITAL STATUS
PLANNED PROGRAM OF STUDY				

STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (<i>follow by description of past history, if complaint exists</i>)			
HAVE YOU HAD OR HAVE YOU NOW			IF YES, PLEASE GIVE DETAILS
YES	NO	DON'T KNOW	<i>(Check each item)</i>
			NERVOUS SYSTEM:
			Frequent or severe headaches
			Head injury/concussion
			Hearing loss
			Vision Loss in one or both eyes
			Wear glasses or contact lenses
			Epilepsy/Seizures
			Dizziness/Unconsciousness
			Paralysis
			CIRCULATORY SYSTEM:
			Heart Disease
			Pain or pressure in chest
			Palpitations or pounding heart
			High or low blood pressure
			Heart or vascular surgery
			Bleeding disorder
			RESPIRATORY SYSTEM:
			Asthma
			Hay Fever
			Chronic Cough
			Shortness of Breath
			Hoarseness
			Coughing up blood
			Tuberculosis
			DIGESTIVE SYSTEM:
			Stomach trouble
			Severe digestive disorder
			Liver trouble
			Intestinal trouble
			Gallbladder trouble
			Jaundice or Hepatitis
			ENDOCRINE SYSTEM:
			Diabetes
			Thyroid dysfunction
			URINARY TRACT SYSTEM:
			Kidney dysfunction
			Kidney stones
			Frequent bladder infections
			MUSCULOSKELETAL SYSTEM:
			Amputations
			Arthritis, Rheumatism
			Impaired range of motion
			Foot trouble
			Impaired balance or coordination

HAVE YOU HAD OR HAVE YOU NOW			IF YES, PLEASE GIVE DETAILS
YES	NO	DONT KNOW	
			(Check each item)
			Swollen or painful joints
			Broken bones
			Back pain
			Wear brace, back support, prosthesis or other assistive device
			Bone, joint or other deformity
			MENTAL HEALTH:
			Psychiatric disorder/mental condition
			Depression
			Attempted suicide
			Loss of memory
			Anxiety disorder
			Alcohol abuse
			Drug abuse
			INFECTIOUS DISEASE
			Sexually transmitted diseases (syphilis, gonorrhea, herpes, genital warts)
			HIV (Human Immunodeficiency Virus)
			Hepatitis A, B or C
			Tuberculosis
			Scarlet fever
			Rheumatic fever
			OTHER:
			Skin diseases
			Debilitating allergies
			Cancer
			Loss of Vision
			Glaucoma
			Other eye diseases
			Loss of Hearing
			Recent or repetitive surgery
			Sleepwalking
			Severe speech impediment
			Other illness, injury, or disability
			Learning disability
			Attention deficit disorder
			Frequent trouble sleeping
			Adverse reaction to serum, drug or medicine? What?
			Have you ever been refused employment or been unable to hold a job or stay in school because of:
			1. Sensitivity to chemicals, dust, sunlight, etc.
			2. Inability to perform certain motions
			3. Inability to assume certain positions
			4. Other medical reasons (specify)
			Have you ever been denied life insurance? (specify)
			Have you had or been advised to have any operations? (specify)
			Have you ever been a patient in any type of hospital? (specify)
			Have you ever been rejected for military service because of physical, mental or other reasons? (specify)
			Have you ever been discharged from military service because of a physical, mental or other reason? (specify)
			Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (specify)
			Are you <input type="checkbox"/> right-handed <input type="checkbox"/> left-handed?
<p>I certify that 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 complete transcript of my medical record for purposes of processing my application.</p>			
TYPED OR PRINTED NAME OF EXAMINEE			SIGNATURE
<p>Physician's summary and elaboration of all pertinent data. (Physician shall comment on all positive answers. Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)</p>			
TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER		DATE	NUMBER OF ATTACHED SHEETS
		SIGNATURE	

This section must be completed in full prior to admission for all license candidates. Please be certain that the TYPE of color vision testing is reported. Only the following tests can be used: (*Please circle one*)

- (1) PSEUDOISOCROMATIC PLATES (DVORINE, 2ND EDITION; AOC: REVISED EDITION OR ADC-HRR: ISHIHARA 16-, 24-, OR 38- PLATE EDITIONS)
- (2) ELDRIDGE-GREEN COLOR PERCEPTION LANTERN
- (3) FARNSWORTH LANTERN
- (4) KEYSTONE ORTHOSCOPE
- (5) KEYSTONE TELEBINOCULAR
- (6) SAMCTT (SCHOOL OF AVIATION MEDICINE COLOR THRESHOLD TESTER)
- (7) TITMUS OPTICAL VISION TESTER
- (8) WILLIAMS LANTERN

Please provide both corrected and uncorrected acuity.	
DISTANT VISION	
<u>RIGHT</u>	<u>LEFT</u>
Uncorrected 20/	Uncorrected 20/
Corrected 20/	Corrected 20/
Color vision (test used and result)	
Visual Field to Confrontation	

TITLE 46 CODE OF FEDERAL REGULATIONS, PART 10.205 (d) (2) & (3) requires an applicant for a license to have uncorrected vision of at least 20/200 in each eye correctable to at least 20/40 in each eye (Deck), and 20/50 in each eye (Engineer).

If your uncorrected vision is worse than 20/200 or your corrected vision is worse than 20/40 (Deck) or 20/50 (Engineer) in either eye submit:

A detailed report from your ophthalmologist/optometrist stating your **uncorrected and corrected vision in both eyes** and a complete diagnosis of your eye condition **along with a prognosis**. This report must be current and on the ophthalmologist's/optometrist's letterhead stationery.

PHYSICIAN'S/OPTOMETRIST'S SIGNATURE _____ DATE _____

PLEASE DO NOT FILL OUT THE SECTION BELOW

MMA MEDICAL DEPARTMENT REVIEW:

_____ PHYSICALLY QUALIFIED FOR DECK OR ENGINE.

_____ DISQUALIFIED/NOT WAIVERABLE. REASON: _____ Inadequate information
 _____ Visual Acuity
 _____ Color Vision
 _____ Hearing
 _____ Other _____

_____ DISQUALIFIED FOR DECK DUE TO COLOR VISION BUT QUALIFIED FOR ENGINE.

_____ DISQUALIFIED FOR DECK OR ENGINE BUT WAIVERABLE. REASON: _____ Visual Acuity
 _____ Color Vision
 _____ Hearing
 _____ Other _____

MMA PHYSICIAN'S SIGNATURE _____ DATE _____

MAINE MARITIME ACADEMY
Castine, Maine
REPORT OF MEDICAL EXAMINATION

MEASUREMENTS AND OTHER FINDINGS

HEIGHT	WEIGHT	COLOR HAIR	COLOR EYES	BUILD <input type="checkbox"/> SLENDER <input type="checkbox"/> MEDIUM	DATE OF EXAMINATION
				<input type="checkbox"/> HEAVY <input type="checkbox"/> OBESE	
CLINICAL EVALUATION			TEMPERATURE	BLOOD PRESSURE	PULSE

NORMAL	<i>(Check each item in appropriate column, enter "NE" if not evaluated)</i>	ABNORMAL	NOTES
	HEAD, FACE, NECK AND SCALP		<i>Describe every abnormality in detail. (Use additional sheets if necessary).</i>
	NOSE		
	SINUSES		
	MOUTH AND THROAT		
	EARS		
	EYES		
	OPHTHALMOSCOPIC		
	PUPILS		
	OCULAR MOTILITY		
	LUNGS AND CHEST <i>(include breasts)</i>		
	HEART		
	VASCULAR SYSTEM		
	ABDOMEN AND VISCERA <i>(include hernia)</i>		
	ANUS AND RECTUM <i>(Prostate, if indicated)</i>		
	ENDOCRINE SYSTEM		
	G-U-SYSTEM		
	UPPER EXTREMITIES		
	FEET		
	LOWER EXTREMITIES		
	SPINE, OTHER MUSCULOSKELETAL		
	IDENTIFYING BODY MARKS, SCARS, TATTOOS		
	SKIN, LYMPHATICS		
	NEUROLOGIC		
	PSYCHIATRIC <i>(Specify any personality deviation)</i>		

Hearing

Audiometer (Threshold Value)	500 Hz	1000 Hz	2000 Hz	3000 Hz
Right Ear (Unaided)				
Left Ear (Unaided)				
Right Ear (Aided)				
Left Ear (Aided)				

Functional Speech Discrimination Test at 55 dB (if indicated)	Right Ear (Unaided) _____ %	Left Ear (Unaided) _____ %
	Right Ear (Aided) _____ %	Left Ear (Aided) _____ %

<p>SUMMARY OF DEFECTS AND DIAGNOSES</p> <p><input type="checkbox"/> Is qualified for vigorous physical activity</p> <p><input type="checkbox"/> Is not qualified for vigorous physical activity</p>	<p>RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED <i>(Specify)</i></p>
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TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
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