NAVAL HEALTH CLINIC HAWAII (Bldg 1750)
480 CENTRAL AVENUE
JOINT BASE PEARL HARBOR HICKAM, HAWAII 96860-4908

APPRENTICE PROGRAM APPLICANTS

You need to complete, to the best of your ability, all paperwork provided to you by the Naval Health Clinic, via HRO. It is absolutely critical that you complete this paperwork AND bring it with you when you come to the SHIPYARD Health Clinic (above address) for your medical visit on the first Saturday of processing. You will be scheduled for a follow-up appointment at the conclusion of your first day medical visit. During your follow-up appointment, you will be seen by one of the clinic's healthcare providers and your physical examination will be completed.

You should bring the following items with you on your first visit (Saturday):

- All medical paperwork. It should be completed before your arrival.
- If you wear corrective lenses, please bring them. You should bring/wear glasses; please do not wear contact lenses to this appointment.
- If you currently take any medications, (prescribed medications, over-the-counter/non-prescription medications, herbal supplements, weight gain/loss supplements, etc.,) please provide a list to include: medication, dose and how often you take them.

Everyone will need to provide a urine sample and blood for testing - these are medical tests, NOT drug screening tests. You are encouraged to drink plenty of water. IF you are in the RIGGER PROGRAM, do not eat, drink, chew gum or use any tobacco products for 12 hours before your appointment. You may drink water.

You may also want to bring a light snack which can be eaten after your blood is drawn. Refrigerator space is not available.

If you need to contact the medical clinic, please call 471-8066, ext 353.

PATIENT REGISTRATION UPDATE FORM(CIVILIAN)

PLEASE PRINT ALL INFOFMATION CLEARLY!!!!!!!

NAME: _____

LAST, FIRST M I

FULL SSN: _____/_____/_____

DATE OF BIRTH:_____//_____//_____

MONTH DAY YEAR

WORK PHONE:_____ X_____

HOME PHONE:_____

CELL PHONE:_____

E-MAIL ADDRESS:_____

HOME ADDRESS:_____

CITY:_____ ZIP CODE:_____

DRUG ALLERGIES:(IF NONE WRITE NONE)_____

_____

NO. OF ATTACHED SHEETS:

MEDICAL RECORD	REPORT OF MEDICAL HISTORY	DATE OF EXAM

NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

1. NAME OF PATIENT *(Last, first, middle)*			2. IDENTIFICATION NUMBER	3. GRADE
4a. HOME STREET ADDRESS *(Street or RFD; City or Town; State; and ZIP Code)*			5. EXAMINING FACILITY NHCH SHIPYARD, 480 CENTRAL AVENUE JBPHH, HI 96860-4908	
4b. CITY	4c. STATE	4d. ZIP CODE		

6. PURPOSE OF EXAMINATION

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Use additional pages if necessary)*

a. PRESENT HEALTH	b. CURRENT MEDICATION	REGULAR OR INTERM.
c. ALLERGIES *(Include insect bites/stings and common foods)*		
	d. HEIGHT	e. WEIGHT
8. PATIENT'S OCCUPATION	9. ARE YOU *(Check one)* ☐ RIGHT HANDED ☐ LEFT HANDED	

10. PAST/CURRENT MEDICAL HISTORY

CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW
Household contact with anyone with tuberculosis				Shortness of breath				Bone, joint or other deformity			
				Pain or pressure in chest				Loss of finger or toe			
Tuberculosis or positive TB test				Chronic cough				Painful or "trick" shoulder or elbow			
Blood in sputum or when coughing				Palpitation or pounding heart							
				Heart trouble				Recurrent back pain or any back injury			
Excessive bleeding after injury or dental work				High or low blood pressure							
				Cramps in your legs				"Trick" or locked knee			
Suicide attempt or plans				Frequent indigestion				Foot trouble			
Sleepwalking				Stomach, liver or intestinal trouble				Nerve Injury			
Wear corrective lenses				Gall bladder trouble or gallstones				Paralysis *(including infantile)*			
Eye surgery to correct vision								Epilepsy or seizure			
Lack vision in either eye				Jaundice or hepatitis				Car, train, sea or air sickness			
Wear a hearing aid				Broken bones				Frequent trouble sleeping			
Stutter or stammer				Adverse reaction to medication				Depression or excessive worry			
Wear a brace or back support				Skin diseases				Loss of memory or amnesia			
Scarlet fever				Tumor, growth, cyst, cancer				Nervous trouble of any sort			
Rheumatic fever				Hernia				Periods of unconsciousness			
Swollen or painful joints				Hemorrhoids or rectal disease				Parent/sibling with diabetes, cancer, stroke or heart disease			
Frequent or severe headaches				Frequent or painful urination							
Dizziness or fainting spells				Bed wetting since age 12				X-ray or other radiation therapy			
Eye trouble				Kidney stone or blood in urine				Chemotherapy			
Hearing loss				Sugar or albumin in urine				Asbestos or toxic chemical exposure			
Recurrent ear infections				Sexually transmitted diseases							
Chronic or frequent colds				Recent gain or loss of weight				Plate, pin or rod in any bone			
Severe tooth or gum trouble				Eating disorder (anorexia bulimia, etc.)				Easy fatigability			
Sinusitis								Been told to cut down or criticized for alcohol use			
Hay fever or allergic rhinitis				Arthritis, Rheumatism, or Bursitis							
Head injury								Used illegal substances			
Asthma				Thyroid trouble or goiter				Used tobacco			

11. FEMALES ONLY

CHECK EACH ITEM	YES	NO	DON'T KNOW	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR	DATE OF LAST MAMMOGRAM
Treated for a female disorder						
Change in menstrual pattern						

CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER.

ITEM	YES	NO
12. 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.)*		
13. Have you ever been treated for a mental condition? *(If yes, specify when, where, and give details.)*		
14. Have you ever been denied life insurance? *(If yes, state reason and give details.)*		
15. Have you had, or have you been advised to have, any operation. *(If yes, describe and give age at which occurred.)*		
16. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*		
17. 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.)*		
18. Have you ever been rejected for military service because of physical, mental, or other reasons? *(If yes, give date and reason for rejection.)*		
19. 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.)*		
20. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*		
21. Have you ever been arrested or convicted of a crime, other than minor traffic violations. *(If yes, provide details.)*		
22. Have you ever been diagnosed with a learning disability? *(If yes, give type, where, and how diagnosed.)*		

23. LIST ALL IMMUNIZATIONS RECEIVED

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. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

24a. TYPED OR PRINTED NAME OF EXAMINEE	24b. SIGNATURE	24c. DATE

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 7 through 11. Physician may develop by interview any additional medical history deemed important, and record any significiant findings here.)*

26a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	26b. SIGNATURE	26c. DATE

MEDICAL SURVEILLANCE QUESTIONNAIRE

PRIVACY ACT STATEMENT

" The authority to collecting this information is Section 19 of the Occupational Safety and Health Act and the Code of Federal Regulations (29 CFR 1950). This information will be used by the Occupational Health Physician, and/or such clinical staff as he may designate to help identify the causes of adverse health effects and for future epidemiology studies. Providing the information is voluntary; however, failure to provide the information could unnecessarily hamper the identification of potential health problems and preclude any redress of problems identified in the future."

PART I - OCCUPATIONAL HISTORY

Instructions: Please complete the following work history in chronological order from your first job to the present, and list all part-time and full-time jobs you have held. Be as specific as possible; if you held more than one job with the same employer, list each title and activity. Use additional sheets as needed.

TODAY'S DATE	DATES		NO. HRS/WK	JOB TITLE AND WORK ACTIVITIES *(include employer if not Navy)*	POTENTIAL HAZARDS *(Be as specific as possible.)*	PROTECTIVE EQUIPMENT *(Respirator, ear plugs, protective clothing, etc.)*
	FROM	TO				

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*	PATIENT'S Name *(Last, First. Middle initial)*			SEX
	YEAR OF BIRTH	RELATIONSHIP TO SPONSOR	COMPONENT/STATUS	DEPART/SERVICE
	SPONSOR'S NAME			
	SSN OR IDENTIFICATION NO.		ORGANIZATION	

PART II - HOBBIES AND ACTIVE SPORTS *(which may involve hazards)*

Include active sports, secondary jobs held, etc. - include activities such as painting, auto racing, scuba diving, etc.

TODAY'S DATE	DATES		NO. HRS/WK	JOB TITLE AND WORK ACTIVITIES *(include employer if not Navy)*	POTENTIAL HAZARDS *(Be as specific as possible)*	PROTECTIVE EQUIPMENT *(Respirator, ear plugs, protective clothing, etc.)*
	FROM MO/YR	TO MO/YR				

PART III - OTHER EXPOSURES AND WORK-RELATED EXPOSURES

Include informationyou feel may have been harmful to your health from neighborhood exposure to hazardous substances or family members working in a trade where hazardous substances could have been brought home, such as asbestos, lead, beryllium, vinyl chlordie, etc..

TODAY'S DATE	DATES		NO. HRS/WK	JOB TITLE AND WORK ACTIVITIES *(include employer if not Navy)*	POTENTIAL HAZARDS *(Be as specific as possible)*	PROTECTIVE EQUIPMENT *(Respirator, ear plugs, protective clothing, etc.)*
	FROM MO/YR	TO MO/YR				

PART IV - MEDICAL DEPARTMENT DETERMINATIONS

Based on review of this surveillance questionnaire, and other pertinent data, placement in the following medical surveillance program(s) is indicated.

DATE	PROGRAMS	SIGNATURE

AUDIOGRAM HISTORY FORM (civ)

PLEASE PRINT (clearly)

APPRENTRICE PROGRAM

1. SSN _ _ _ - _ _ - _ _ _ _

2. LAST NAME _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

3. FIRST NAME _ _ _ _ _ _ _ _ _ _ _ MI _

4. SEX M F DOB: _ _ //_ _ //_ _
MONTH DAY YEAR

5. DOD COMPONENT N

6. SERVICE COMPONENT FED EMP

7. PAY GRADE _ _ //8. JOB SERIES: _ _ _ _

9. UIC 69198 ///COMMAND SECNAV

10. JOB TITLE_____

11. WORK PHONE 808 - 4 7 0 - 0 0 0 0

SHIPFITTER-3801 SHEET METAL MECHANIC-3801 WELDR- 3701
ELECTRONIC INDUSTRIAL - 2606 ELECTRICIAN- 2801
PRODUCTION MACH MECH-5301 MACHINIST-3401
MARINE MACHINERY MECH-5301
PIPEFITTER-4201 ELECTONICS MEASUREMENT-2601
FABRIC WORKER-3101 INSULATOR-4301 PLASTIC FABRICATOR-4301
PAINTER-4101 SHIPWRIGHT-5201 RIGGER-5201
METALS INSPECTOR-3801

INTERDISCIPLINARY TEACHING RECORD
NAVAL MEDICAL PEARL HARBOR HAWAII

Circle your answer or fill in the blank

A. Are you able to read and write in English? Yes No

B. What is your highest level of education? _____

C. Circle anything that might make it hard for you to learn:

Language Vision Hearing Emotions Thinking

Physical disability Religious beliefs Cultural beliefs

Finances Other: _____ None

D. How do you like to learn?

Listening Reading Hands-on Combination

E. List any health topics you would like more information about:

(Staff only) Plan to address any educational concerns:

For staff only

Learner Code (LC)
PT = Patient
SP = Spouse
P = Parent
OR = Other Relative
O = Other _____

Teaching Method Code (TMC)
V = Video
D = Demonstration
I = One to One
G = Group
H = Handout
L = Lecture
A = Audio
PS = Problem Solving

Evaluation Code (EC)
VU = Verbalizes Understanding
D = Demonstrates without assistance
DP = Demonstrates with assistance
NR = Needs Reinforcement
NA = Learning not accomplished

Date/Time	Information Provided	LC	TMC	EC	Patient Signature	Staff Signature
	EDUCATIONAL ASSESSMENT	PT	I	VU		

RECORDS MAINTAINED AT:		
Patient's Name (*Last, First, MI*)		Sex
Relationship to Sponsor	Status	Rank/Grade
Sponsor's Name		Organization
Depart./Service	SSN/Identification No.	Date of Birth

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER *(SSN)*

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

3. ROUTINE USES

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF PATIENT OR SPONSOR	SSN OF MEMBER OR SPONSOR	DATE

Standard Form 600
April 1974
General Services Administration and
Interagency Comm. on Medical Records
FPMR 101-11.809-3
(O/P PH-NRMC #7 (5-80))

HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

PRELIMINARY ASBESTOS MEDICAL QUESTIONNAIRE

1. Have you ever been exposed to asbestos? YES____, NO____, UNKNOWN_____.

2. Complete the following for each place of exposure to asbestos.

	Place's	From to (Dates)	Position Held
a.			
b.			
c.			
d.			
e.			

3. Type of asbestos exposure. Check one or more.

a.____ Installation or removal of asbestos floor tile.
b.____ Use of asbestos rope pipe caulking.
c.____ Installation or removal of asbestos lagging or pipes.
d.____ Installation or removal of asbestos lagging on equipment.
e.____ Installation or removal of asbestos insulated, cable splices.
f.____ Installation or removal of asbestos brake or clutch lining.
g.____ Use of asbestos cloth.
h.____ OTHERS_____

4. Frequency of exposure, for each asbestos exposure listed in 3 above, place its corresponding latter at the right of the most appropriate frequency listed below.

a.____ Daily
b.____ Four times a day
c.____ Three times a day
d.____ Two times a week
e.____ Once a week
f.____ Four times a month
g.____ Three times a month
h.____ Two times a month
i.____ Once a month
j.____ Times a year

PATIENT'S IDENTIFICATION *(Use this Space for Mechanical Imprint)*

PATIENT'S NAME *(Last, First, Middle initial)*			SEX
YEAR OF BIRTH	RELATIONSHIP TO SPONSOR	COMPONENT/STATUS	DEPART/SERVICE
SPONSOR'S NAME			RANK/GRADE
SSAN OR IDENTIFICATION NO.		ORGANIZATION	

NSN 7540-00-634-4176

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*

ASBESTOS MEDICAL SURVEILLANCE PROGRAM

Naval Medical Clinic

Pearl Harbor, Hawaii 96860-5080

Breathing asbestos dust may be hazardous to your health. IAW OPNAVINST 5100.23 all personnel who have been or who are now, significantly exposed to asbestos are to be included in an Asbestos Medical Surveillance Program (AMSP). While present engineering and environmental controls in addition to personal protective equipment prevent personnel from being exposed to hazardous levels of asbestos dust, periodic medical surveillance is required to assure continued adequacy of control measures and/or detect early asbestos related medical changes. Moreover, IAW CNO MSG 221230Z AUG 79, personnel in selected jobs are being surveyed to determine if they should be included in the Asbestos Medical Surveillance Program.

Have you been exposed to asbestos dust during Rip Out operations or worked regularly with asbestos or asbestos products during your Navy career either in active duty or in a civil service position?

YES NO

(SIGNATURE)

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT:		
PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

COMNAVREG HI
REQUEST FOR MEDICAL CLEARANCE
FOR RESPIRATOR USE QUESTIONNAIRE

_____
DATE

_____	_____	_____
EMPLOYEE	SSN	POSITION
SUPERVISOR	PHONE	COMMAND/DEPT/CODE

CIRCLE THE TYPE OF RESPIRATOR(S) TO BE USED:

AIR-SUPPLIED (tight-fitting)
AIR-SUPPLIED (hooded)
OPEN-CIRCUIT SCBA
CLOSED-CIRCUIT SCBA

AIR-PURIFYING (powered) (tight-fitting)
AIR-PURIFYING (powered) (hooded)
COMBINATION AIRLINE/SCBA
AIR-PURIFYING (non-powered): (Specify)
filtering facepiece or elastomeric
N, P, R 95, 99, 100
Type chemical cartridge_____

WORK EFFORT: (CIRCLE ONE)
Light Moderate Heavy Strenuous

EXTENT OF USAGE: (CIRCLE ONE)
1. On a daily basis
2. Occasionally - but more than once a week
3. Rarely - or for emergency situations only

LENGTH OF AVERAGE WORK DAY IN RESPIRATOR: _____

SPECIAL WORK CONDITIONS: (i.e., high places, temperature/humidity extremes, hazardous materials, other protective clothing worn, climbing, etc.)

_____

_____

MEDICAL WRITTEN EVALUATION

1. No restrictions on the respirators circled above
2. Respirator use with some restrictions
3. No respirator use allowed
4. Alternate respirator recommended

Comments/Restrictions:

_____

_____

_____

	(under 35)	(35-45)	(over 45)
Routine Follow-up medical evaluation required:	5 yrs	2 yrs	1 yr

Or due to medical findings return: Date: _____
Employee has been given a copy of this recommendation.

Health care professional's Signature _____ Date _____

Sections 133, 1071-87, 3012, 5031, and 8012, Title 10 USC & Exec. Order 9397 (Privacy Act of 1974) Apply