PATIENT MEDICATION LIST

Name: JON L WILKINSON S-Num: 44472 SSN: 518-88-2666 Birth Date: 05/23/1961

Close Date	Medication Description
00/00/0000	ALODEPINE
00/00/0000	AMOXICLAV
00/00/0000	SYMBOCORT
00/00/0000	PREDNISONE
00/00/0000	SINGULAR

Name: JON L WILKINSON S-Num: 44472 SSN: 518-88-2666 Birth Date: 05/23/1961

Test Date: 01/31/2011

Glasses Worn: Y Contact Lens Worn: Depth Perception:

Color Vision: Visual Field:

---------- Tanometry (Average of 3 Tests) ----------

Far Vision 20/XXX

Uncorrected			Corrected		
Both	Left	Right	Both	Left	Right
16	20	16	XX	XX	XX

Near Vision 14/XXX

Uncorrected			Corrected		
Both	Left	Right	Both	Left	Right
47	35	35	14	18	14

340.33
03/19/2010
Rev. 03

COMPREHENSIVE MEDICAL QUESTIONNAIRE
(WHEN COMPLETED THIS FORM CONTAINS PAI/OUO)

OFFICIAL USE ONLY

May be exempt from public release under the Freedom of Information Act (5 U.S.C. 552), exemption number and category: 6 Personal Privacy.
Department of Energy review required before public release Name/Org: (b) (6) Date: 02/23/2009 Guidance (if applicable) NA.

This is to be used in the Post-Offer, Pre-Placement time period.

Questionnaire Completion Date: 31 JAN 2011
NOTE: All employees are asked to complete the Occupational Medicine Program Termination Interview when they end their employment at the INL.
NOTE: This information is for Medical Department use only and when completed contains Privacy Act Information. It will not be released to unauthorized persons.

44472

Name of Patient: (Last First, middle)	Date of Birth:	S Number:
WILKINSON Jon Lee	05/23/61	518-88-2666

List previous and present medical conditions (hospitalizations, high blood pressure, cancer, heart disease, etc.) and dates:
Adult Asthma 2010
Heart Blood Pressure 2010

Current Medication	Dosage	Condition treated by this medication	Duration
Singulair	10 mg	Asthma	ONGOING
Symbicort	160 mcg	Asthma	ONGOING
Amox/K clav XR	62.5 mg	Respitory Infection	Comp - 30 days
Prednisone	10 MG	" "	Comp - 30 days
Amlodipine	5 mg.	HBP	Ongoing

SYSTEMIC REVIEW Do you have any of the following

GENERAL	NO	YES
Recent weight change	☒	☐
Have you been in good general health most of your life?	☐	☒

SKIN	NO	YES
Jaundice	☒	☐
Hives, eczema or rash	☒	☐
Abnormal Pigmentation	☒	☐

HEAD-EYES-EARS-NOSE-THROAT	NO	YES
Eye disease or injury	☒	☐
Do you wear glasses or contacts?	☒	☐
Double vision	☒	☐
Headaches	☒	☐
Glaucoma	☒	☐
Itching eyes or nose	☒	☐
Sneezing or runny nose	☒	☐
Nosebleeds	☒	☐
Chronic sinus trouble	☐	☒
Ear disease	☒	☐
Impaired hearing	☒	☐
Dizziness or transient episodes of unconsciousness	☒	☐

NECK	NO	YES
Stiffness	☒	☐
Enlarged glands	☒	☐

RESPIRATORY	NO	YES
Emphysema	☒	☐
Spitting up blood	☒	☐
Chronic / frequent cough	☒	☐
Asthma or wheezing	☐	☒
Difficulty breathing	☒	☐
Pleurisy or pneumonia	☒	☐

CARDIOVASCULAR	NO	YES
Chest pain or angina pectoris	☒	☐
Shortness of breath while talking or lying down	☒	☐
Difficulty walking two blocks	☒	☐
Heart trouble or heart attacks	☒	☐
High blood pressure	☐	☒
Swelling of hands, feet or ankles	☒	☐
Awakening in the night smothering	☒	☐

GASTROINTESTINAL	NO	YES
Peptic ulcer	☒	☐
Vomiting blood or food	☒	☐
Gallbladder disease	☒	☐
Liver disease	☒	☐
Hepatitis	☒	☐
Painful bowel movements	☒	☐
Black stools	☒	☐
Hemorrhoids	☒	☐
Recent change in bowel habits	☒	☐
Frequent diarrhea	☒	☐
Heartburn or indigestion	☒	☐
Cramping or pain in the abdomen	☒	☐

GENITOURINARY	NO	YES
Frequent urination	☒	☐
Recurrent bladder infections	☒	☐
Burning or painful urination	☒	☐
Blood in urine	☒	☐
Kidney disease	☒	☐
Kidney stones	☒	☐

ALLERGY	NO	YES
Any hay fever/environmental allergies	☒	☐

340.55
03/19/2010
Rev. 03

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LOCOMOTOR-MUSCULOSKELETAL	NO	YES
Varicose veins	☐	☑
Difficulty walking	☑	☐
Pain in calves caused by walking relieved by rest	☑	☐

NEURO-PSYCHIATRIC	NO	YES
Have you ever had psychiatric care	☑	☐
Have you been advised to see a psychiatrist	☑	☐
Do you ever have or have you ever had:	☐	☐
- Fainting spells	☑	☐
- Convulsions	☑	☐
- Paralysis	☑	☐
Heat or cold intolerance	☑	☐

HEMATOLOGIC	NO	YES
Are you slow to heal after cuts	☑	☐
Blood disease	☑	☐
Anemia	☑	☐
Phlebitis	☑	☐
Have you had difficulty with bleeding excessively after tooth extraction or surgery	☑	☐
Have you had abnormal bruising or bleeding	☑	☐

ENDOCRINE	NO	YES
Thyroid disease	☑	☐
Hormone therapy	☑	☐
Any change in hair growth	☑	☐

PAST / CURRENT MEDICAL HISTORY

Past (or current) exposure information including any of the following IH sampling, and past certifications/surveillances (list any exposure to asbestos or beryllium regardless of time).

CHECK EACH ITEM	NO	YES
Household contact with anyone with tuberculosis	☑	☐
Tuberculosis or positive TB test	☑	☐
Eye surgery to correct vision	☑	☐
Blindness in either eye	☑	☐
Hearing loss	☑	☐
Recurrent ear infections	☑	☐
Wear a hearing aid	☑	☐
Frequent or severe headaches	☑	☐
Severe migraines	☑	☐
Dizziness or fainting spells	☑	☐
Head injury	☑	☐
Epilepsy or seizure	☑	☐
Chronic or frequent colds	☑	☐
Sinusitis	☐	☑
Asthma	☐	☑
Blood in sputum or when coughing	☑	☐
Chronic cough	☑	☐
Palpitation or pounding heart	☑	☐
Frequent indigestion	☑	☐
Adverse reaction to medication	☑	☐
Skin disease, rash or changing mole	☑	☐
Tumor, growth, cyst	☑	☐
Cancer	☑	☐
Hernia	☐	☑
Kidney stone or blood in urine	☑	☐
Sugar or albumin in urine	☑	☐
Eating disorder (anorexia, bulimia, etc.)	☑	☐
Broken bones	☑	☐
Bone, joint or other deformity	☑	☐
Swollen or painful joints	☑	☐
Loss of finger or toe	☑	☐
Painful or "trick" shoulder or elbow	☑	☐

CHECK EACH ITEM	NO	YES
Recurrent back pain or any back injury	☑	☐
Wear a brace or back support	☑	☐
"Trick" or locked knee	☑	☐
Foot trouble	☑	☐
Plate, pin or rod in any bone	☑	☐
Nerve injury	☑	☐
Cramps in your legs	☑	☐
Birth defects, inherited disease	☑	☐
Frequent trouble sleeping	☐	☑
Sleepwalking	☑	☐
Depression or excessive worry	☑	☐
Suicide attempt or plans	☑	☐
Anxiety	☑	☐
Loss of memory or amnesia	☑	☐
Nervous trouble of any sort	☑	☐
Periods of unconsciousness	☑	☐
Easy fatigability	☑	☐
Diabetes or insulin resistance	☑	☐
X-ray or other radiation therapy	☑	☐
Chemotherapy	☑	☐
Been told to cut down or criticized for alcohol use	☑	☐
Used illegal substances	☑	☐
Used tobacco	☑	☐
Hair problems	☑	☐
Anemia, bleeding disorder, sickle cell	☑	☐
Breast disease	☑	☐
Clots, embolism, stroke	☑	☐
Varicose veins, phlebitis	☐	☑
Rheumatic fever	☑	☐
Scarlet fever	☑	☐
Arthritis, rheumatism or bursitis	☑	☐

03/19/2010
Rev. 03

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PAST/CURRENT EXPOSURE HISTORY

Approximate Dates	Employer(s)/Location(s)	Former Surveillances/Certifications	Description(s) of work performed/work conditions/exposure information
		Arsenic Medical Surveillance	
		Asbestos Worker Medical Surveillance	
		Beryllium Medical Surveillance	
		Cadmium Medical Surveillance	
		Formaldehyde Medical Surveillance	
		Hazardous Waste Operations Medical Surveillance	
		Hearing Conservation Program Medical Surveillance	
		Hexavalent Chromium Medical Surveillance	
		Laser Personnel Medical Surveillance	
		Lead Medical Surveillance	
		DOT Driver Certification	
		Hoisting and Rigging Certification	
		Respirator User Certification	
1991/1995	TAN	Other	LINE PERSON @ WAREHOUSE
		Other	

NOTIFICATION OF WORK TERMINATION EXIT MEDICAL EXAM

At the time of separation from employment a general health evaluation to establish a record of physical condition is available upon request by the employee. If an employee elects to receive an evaluation, the evaluation must be completed within 3 weeks of termination or as scheduled by OM if OM cannot schedule the evaluation within the initial 3 week window.

By virtue of your signature below, you signify that you understand that failure to contact OM to schedule an evaluation automatically defaults to a "declined" status for the health evaluation immediately following the 3 week window from the time of separation.

Signature: _____ Date: 30 JAN 2011

340.00
03/19/2010
Rev. 03

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Check item. If "yes" explain in blank space to right. List explanation by item number.

QUESTION	YES	NO	EXPLANATION
1. 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)	☐	☒	
2. Have you ever been denied life insurance? (If yes, state reason and give details)	☐	☒	
3. Have you had, or have you been advised to have, any operation? (If yes, describe and give age at which this occurred.)	☒	☐	Hernia Age 4ish
4. 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.)	☒	☐	Hernia – Oct 2009 IFRMC
5. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the last 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)	☒	☐	CARY JACKSON – Portneuf Med 777 Hospital Way Poc. ID 239-2640
6. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give details and reason for rejection.)	☐	☒	
7. 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.)	☐	☒	
8. 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.)	☐	☒	
9. Have you ever been diagnosed with a learning disability? (If yes, give type, where, and how diagnosed.)	☐	☒	
10. List travel to underdeveloped foreign countries including year of travel and duration of stay.	☐	☒	
11. Do you require any work restrictions or accommodations? (If yes, explain).	☐	☒	

LIST ALL IMMUNIZATIONS RECEIVED:

All Childhood Required

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 understand that falsification of information on this form could result in termination of my employment.

Signature: [signature] Date: 30 JAN 2011

A. May proceed to work assignment, medical requirements are fulfilled ☐

B. Needs to be evaluated by a medical provider ☐

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER:	SIGNATURE:	DATE:

If filling this form out by hand, contact/submit completed forms to:
WCB Medical Dispensary P.O. Box 1625 Idaho Falls, ID 83415-3125 or fax to 208-526-8631