MEDICAL RECORD — IONIZING RADIATION MEDICAL EXAMINATION

1. Type of Examination: ☐PE ☐RE ☐SE ☐TE

2. Examining Facility:

3. Date of Exam:

Medical History (to be completed by patient)	Y	N
4. History of accidental or occupational exposure to ionizing radiation above Table III radiation limits?		
5. History of cancer or precancerous lesions?		
6. History of anemia?		
7. History of radiation therapy?		
8. History of radiopharmaceutical received for therapeutic or experimental purposes?		
9. History of work involving the handling of unsealed radium sources or other unsealed sources?		
10. Have you had any significant illnesses or changes in your medical history since your last examination?		
11. Are you currently taking any medications? If yes, please list:		
12. Do you have any known allergies to medication or iodine?		

Laboratory Data

13. CBC Date:

Record facility lab range if applicable.

		Results	Facility Lab Range	Table I Range	Table II Range
HCT	M			40-52%	35-56%
	F			37-47%	
WBC				4-12k/mm^3	3.5-14k/ mm^3

14. Differential WBC Count (If required) Date:

N____ L____ E____ Baso____ M____ Band____ ATL____

15. Urinalysis Date:

RBC:_____ Heme: ☐+ ☐-

16. Microscopic (If >5 RBCs or Heme+):

17. Other Laboratory Tests:

18. **Vitals**

HT:	WT:
T:	P:
R:	BP:

Physical Examination

	NML	ABL	N/A
19. Eyes			
20. Ears			
21. Nose			
22. Mouth/Throat			
23. Thyroid			
24. Lungs			
25. Breast (F≥36)			
26. Abdomen			
27. Testes			
28. Anus & Rectum			
29. DRE (M≥36)			
30. Lymphatic			
31. Skin			

32. Other:

33. **Summary of Abnormal Findings and Recommendations:** (Note: Medical Examiner must address all abnormal medical history, laboratory, and physical exam findings. For each finding, note whether the condition is considered disqualifying (CD) or not considered disqualifying (NCD) and the basis for such determination.) Continue on back if necessary.

34. **Assessment:** ☐**PQ** / ☐**NPQ for Ionizing Radiation Work**

35. The results of this examination have been explained to me. Date:

Patient's Signature:

36. Printed Name or Stamp of Examiner:	Examiner's Signature:	Date:
37. Printed Name or Stamp of Reviewing Physician:	Physician's Signature:	Date:

38. **Patient Identification** — Last / First / MI

Name:

Command:	Rank/Grade:	Dept/Service:
Social Security Number:	DOB:	

Additional Notes: