Thank you for preparing to visit Employee Occupational Health (EOH) for a physical exam under the Volunteer Transportation Service Program. The Veterans Health Administration (VHA) depends on volunteers like you to help veterans get the care they need and may otherwise be unable to obtain. The VHA has guidelines that limit those who can drive other Veterans-

Specific conditions that prevent medical clearance-

1. Ongoing treatment for epilepsy and seizure disorders.
2. Strokes or TIAs within the previous 12 months
3. Myocardial infarction (heart attack) within the previous 12 months even if treated with stents.
4. Uncontrolled hypertension with BP readings above 160/95.
5. Implantable Cardioverter Defibrillator (ICD).
6. Container oxygen use.
7. Significant Heart Block

Additional Documentation may be needed for medical clearance-Please bring the following with you to the exam if applicable:

List of current medications;
-Any assistive devices you use, such as eyeglasses and hearing aids;
-Pulmonary issues (Sleep Apnea)-
New drivers Medical records covering any sleep study and printed downloads
Renewals -Printed downloads from **CPAP/BiPAP within the past 6 months**
-Diabetes control (**hemoglobin A1C within last 6 months**)
-Any recent cardiac surgery (**within 12 months**)- including bypass, valve replacement or stent procedure- Please provide-operative report and cardiology clearance for returning drivers or any heart surgery operative report, echocardiogram results, and cardiology clearance for new drivers this.
-Documentation that cardiac pacemaker is functioning properly within **1 month**
-Substance abuse -doctor's note evidence of abstinence for **12 months**.

Voluntary Services will assist you in scheduling an appointment to further determine your ability to drive.
If you are not cleared for a driving assignment, we hope you will consider volunteering for other services. We appreciate your participation in our Volunteer Program.

If you have any questions and would like to speak with a provider prior to scheduling a physical please feel free to contact us at 612-467-2985. If a provider is not available when you call one will return your call as soon as possible.

Peter T. Mitchell, MSN, APRN, FNP-BC, COHN-S
Occupational Health Provider

Steven R. Kirkhorn, MD, MPH
Medical Director

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

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
Household contact with anyone with tuberculosis			
Tuberculosis or positive TB test			
Blood in sputum or when coughing			
Excessive bleeding after injury or dental work			
Suicide attempt or plans			
Sleepwalking			
Wear corrective lenses			
Eye surgery to correct vision			
Lack vision in either eye			
Wear a hearing aid			
Stutter or stammer			
Wear a brace or back support			
Scarlet fever			
Rheumatic fever			
Swollen or painful joints			
Frequent or severe headaches			
Dizziness or fainting spells			
Eye trouble			
Hearing loss			
Recurrent ear infections			
Chronic or frequent colds			
Severe tooth or gum trouble			
Sinusitis			
Hay fever or allergic rhinitis			
Head injury			
Asthma			

CHECK EACH ITEM	YES	NO	DON'T KNOW
Shortness of breath			
Pain or pressure in chest			
Chronic cough			
Palpitation or pounding heart			
Heart trouble			
High or low blood pressure			
Cramps in your legs			
Frequent indigestion			
Stomach, liver or intestinal trouble			
Gall bladder trouble or gallstones			
Jaundice or hepatitis			
Broken bones			
Adverse reaction to medication			
Skin diseases			
Tumor, growth, cyst, cancer			
Hernia			
Hemorrhoids or rectal disease			
Frequent or painful urination			
Bed wetting since age 12			
Kidney stone or blood in urine			
Sugar or albumin in urine			
~~Sexually transmitted diseases~~			
Recent gain or loss of weight			
Eating disorder (anorexia bulimia, etc.)			
Arthritis, Rheumatism, or Bursitis			
Thyroid trouble or goiter			

CHECK EACH ITEM	YES	NO	DON'T KNOW
Bone, joint or other deformity			
Loss of finger or toe			
Painful or "trick" shoulder or elbow			
Recurrent back pain or any back injury			
"Trick" or locked knee			
Foot trouble			
Nerve Injury			
Paralysis *(including infantile)*			
Epilepsy or seizure			
Car, train, sea or air sickness			
Frequent trouble sleeping			
Depression or excessive worry			
Loss of memory or amnesia			
Nervous trouble of any sort			
Periods of unconsciousness			
~~Parent/sibling with diabetes, cancer, stroke or heart disease~~			
X-ray or other radiation therapy			
Chemotherapy			
Asbestos or toxic chemical exposure			
Plate, pin or rod in any bone			
Easy fatigability			
Been told to cut down or criticized for alcohol use			
Used illegal substances			
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