DEPARTMENT OF HOMELAND SECURITY
U.S. Immigration and Customs Enforcement

MEDICAL EXAMINATION AND HISTORY REPORT

INSTRUCTIONS FOR COMPLETING FORM

(PLEASE DO NOT WRITE IN "EXAMINING FACILITY USE ONLY" AREAS)

SELECTEES: Complete page 1 through 8 before reporting for the medical examination. Please print or type. Each "yes" answer to a medical history question requires that you provide a brief explanation in the comment section provided. **Failure to answer any questions or disclose a known medical condition or history of a medical condition or injury or failure to place signature where indicated may result in removal from further consideration for employment.** This examination is being conducted for employment purposes only; it does not substitute for a periodic health examination conducted by your private provider.

(NOTE: This exam may include a fitness test, please dress appropriately.)

***ATTENTION VETERANS:** All mental health counseling or treatment, to include counseling that was "strictly related to adjustments from service in a military combat environment", **must** be disclosed on this Medical Examination and History Report form to determine if you meet the medical qualifications for the position.

PRIVACY ACT STATEMENT

AUTHORITY: 5 C.F.R. § 339, Medical Qualification Determinations authorize the collection of this information. Collection of your Social Security Number (SSN) is authorized by Executive Order 9397, as amended.

PURPOSE: Your information is being collected to perform a pre-employment medical examination. This form is used as part of the pre-employment hiring process which collects information for the purpose of employment consideration.

ROUTINE USES: Your SSN will be used to uniquely identify you. For United States Citizens, Lawful Permanent Residents, or individuals whose records are covered by Judicial Redress Act of 2015, 5 U.S.C. § 552 a note, your information may be disclosed in accordance with the Privacy Act of 1974, 5 U.S.C. § 552a(b), including pursuant to the routine uses published in the OPM/GOVT-1, General Personnel Records System of Records Notice (SORN), OPM/ GOVT-5- Recruiting, Examining, and Placement Records SORN, and OPM/GOVT-10-Employee Medical File SORN and which can be viewed at **www.dhs.gov/privacy**.

DISCLOSURE: Furnishing this information, including your SSN is voluntary; however, if you do not provide the information then ICE may determine you are ineligible for employment.

SELECTEE'S NAME (Last, First, Middle Initial):		SOCIAL SECURITY NUMBER (SSN)/ IDENTIFICATION (ID) NUMBER:
VETERAN'S PREFERENCE ELIGIBILITY: ☐ Yes ☐ No If yes, specify below: ☐ 5-point preference ☐ 10-point reference	SEX: ☐ Male ☐ Female	DATE OF BIRTH (mm/dd/yyyy):
YOUR CURRENT OCCUPATION:	YOUR CURRENT EMPLOYER:	
HOW LONG IN CURRENT POSITION? (years/months)		
PURPOSE OF EXAMINATION: ☐ Pre-Employment Exam ☐ Periodic Exam		

CHECK THE OCCUPATION FOR WHICH YOU ARE BEING CONSIDERED:

- ☐ Criminal Investigator (GS-1811)
- ☐ Deportation Officer (GS-1801)
- ☐ Police Officer (GS-0083)
- ☐ Law Enforcement Training Specialist (GS-1701)
- ☐ Physical Security Specialist (GS-0800)
- ☐ Other: _____

Health care professionals and examiners: Please avoid adding PII in comments.

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

EXAMINING FACILITY USE ONLY

EXAMINING FACILITIES: **(Do NOT bill examinee for exam. The vendor is responsible for all payments.)** Conduct medical exam and all other required services in accordance with instructions provided by the contracting organization. Complete this form except where indicated. Please print or type.

NAME AND ADDRESS OF EXAMINING FACILITY:	NAME OF EXAMINER: PHONE NUMBER (including area code):

REQUIRED SERVICES (check when completed and attach reports):

- ☐ Medical History and Examiner Review
- ☐ General Physical Examination (including waist measurements and fitness questionnaire)
- ☐ Tuberculosis (TB) Test
- ☐ Fitness Step Test (if applicable)
- ☐ EKG (with signed interpretation)
- ☐ Audiometry
- ☐ Repeat Audiometry (if appropriate)
- ☐ Vision Screening
- ☐ Examiner Review and Comments

MEDICAL HISTORY

(Selectee to Complete This Section)

Check "yes" or "no" for **each** item. For each "yes", you must provide an explanation in the space below. **Explanations to "yes" answers must include date, body part affected, description of injury/issue, and type of treatment.**

1. Have you ever been refused employment or been unable to hold a job or stay in school due to any medical condition? (If yes, specify date, where and give details.) ☐ Yes ☐ No

2. Have you had any surgery or operation? (If yes, describe and give date, details or problem, and name of procedure) ☐ Yes ☐ No

3. Have you been advised to have any surgery or operation, but chose not to have that treatment? (If yes, describe and give date, details or problem, and name of procedure.) ☐ Yes ☐ No

4. Have you ever been a patient in any type of hospital or emergency room? (If yes, specify date, where, why) ☐ Yes ☐ No

5. Have you consulted or been treated by clinics, physicians, healers, or other practitioners for other than minor illness for which no medications were prescribed? (If yes, give date and complete details) ☐ Yes ☐ No

6. Have you ever been rejected for or separated from military service because of physical, mental or other medical reasons? (If yes, give date and reason) ☐ Yes ☐ No

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

7. Have you ever applied for or received VA (Veteran's Administration) disability? (If yes, please attach a copy of all rating decisions, or application if pending decision) ☐ Yes ☐ No

Percentage Granted: _____ % Year Granted: _____

Issue and Related Percentage (for example, PTSD 50%, etc.):

8. Have you ever applied for or received pension or compensation for a non-VA disability? (If yes, please attach a copy of all rating decisions, or application if pending decision) ☐ Yes ☐ No

Type of Disability (SSDI, Worker's Comp, etc.):

Permanent or Temporary: _____ Percentage Granted: _____ % Year Granted: _____

Issue and Related Percentage:

9. Are you: ☐ Left Handed OR ☐ Right Handed

10. Do you take any medications or use inhalers? ☐ Yes ☐ No

If yes, list prescription and non-prescription medications, dosage, and reason for taking (including inhalers).

Medication	Dosage/Frequency	Reason	Currently Taking	Taken in the Past Year
1.			☐	☐
2.			☐	☐
3.			☐	☐
4.			☐	☐

*Attach additional sheets if necessary.

11. Do you have allergies? ☐ Yes ☐ No

If yes, do you carry an Epipen? ☐ Yes ☐ No

If you have allergies, list substances to which you are allergic, the type of reaction, and any medications taken for treatment. If any allergies are to foods, explain if you can be exposed to them (skin contact) without having a reaction.

What are you allergic to?	Specify the allergy and type of reaction (rash, breathing problem, etc.)	Medications Used
☐ Environmental		
☐ Food (including peppers)		
☐ Insects (bees or other stinging insects)		
☐ Animals		
☐ Medication		

*Attach additional sheets if necessary.

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

MEDICAL HISTORY
(Selectee to complete this section)

Do you currently have, or have any history of the following? Describe all " YES " answers on page 6.

	YES	NO
EYES		
12. Detached retina or surgery to repair	☐	☐
13. Cataracts or surgery for cataracts	☐	☐
14. Glaucoma	☐	☐
15. Keratoconus	☐	☐
16. Strabismus or "lazy eye" or any surgery to correct these	☐	☐
17. Any other eye disease, injury, or surgery	☐	☐
VISION		
18. Wear contacts *If yes, how long:	☐	☐
19. Wear glasses *If yes, bring your eyeglasses with you to your appointment	☐	☐
20. Surgery to improve vision (RK, PRK, LASIK, etc.) *If yes, year:	☐	☐
21. Loss of vision in either eye	☐	☐
22. Color vision deficiency or color blindness	☐	☐
23. Night vision deficiency or night blindness	☐	☐
24. Blurred or double vision	☐	☐
EARS		
25. Perforated ear drum or tubes in ear drum(s)	☐	☐
26. Chronic ear pain/infection	☐	☐
27. Ear surgery	☐	☐
28. Loss of balance or vertigo	☐	☐
29. Ringing or buzzing	☐	☐
HEARING		
30. Difficulty hearing	☐	☐
31. Hearing loss	☐	☐
32. Prescribed and/or wear a hearing aid *If yes, specify: ☐ Right ☐ Left ☐ Both	☐	☐
33. Loud, constant noise within past 15 hours	☐	☐
34. Loud, sudden noise within past 15 hours	☐	☐
NOSE, SINUSES, MOUTH, LARYNX		
35. Ear, nose, or throat trouble or disease	☐	☐
36. Chronic sinus infections	☐	☐
37. Recurrent nose bleeds *If yes, last episode _____	☐	☐
38. Absence of, or disturbance of sense of smell	☐	☐
39. Any surgery of your face, mandible, or jaw	☐	☐
LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM		
40. Shortness of Breath	☐	☐
41. Wheezing	☐	☐
42. Chronic Bronchitis	☐	☐
43. Chronic cough or frequent coughing at night	☐	☐
44. Collapsed lung or other lung disease	☐	☐
45. History of chest/chest wall/or breast surgery	☐	☐

	YES	NO
LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM (cont'd)		
46. Asthma (after age 13) *If yes, date of last ER visit(s) or hospitalization(s):	☐	☐
47. Inhaler use *If yes, how often: Last Used:	☐	☐
48. Other breathing problems worsened by exercise, weather, pollen, etc.	☐	☐
HEART		
49. Heart murmur or valve problem	☐	☐
50. Palpitation, pounding heart or abnormal heartbeat	☐	☐
51. Heart surgery	☐	☐
52. Pain or pressure in the chest	☐	☐
53. Abnormal electrocardiogram (EKG)	☐	☐
54. Heart problems or heart disease	☐	☐
ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM		
55. Stomach, esophageal or intestinal ulcer	☐	☐
56. Difficulty swallowing	☐	☐
57. Frequent indigestion or heartburn	☐	☐
58. Gall bladder trouble or gallstones	☐	☐
59. Liver disease or Hepatitis	☐	☐
60. Hernia	☐	☐
61. Surgery to remove or repair a portion of the intestine (other than appendix)	☐	☐
62. Chronic or recurrent intestinal problem such as Irritable Bowel Syndrome, Crohn's disease, Ulcerative Colitis, or Celiac Disease	☐	☐
63. Rectal disease, hemorrhoids, or blood from rectum	☐	☐
64. Hemorrhoid surgery	☐	☐
65. Bariatric surgery (weight loss surgery)	☐	☐
FEMALES		
66. Currently pregnant	☐	☐
67. Chronic pelvic pain	☐	☐
68. Diagnosed with endometriosis or ovarian cysts	☐	☐
69. Evaluation, treatment, or surgery for any other gynecological (female) disorder	☐	☐
70. Permanent complications of any sexually transmitted disease	☐	☐
71. Malignant disease of the bladder, kidney, ureter, cervix, ovaries, breasts, etc.	☐	☐
MALES		
72. Varicocele, hydrocele, or any scrotal mass, swelling or pain	☐	☐
73. Prostate problems	☐	☐
74. Permanent complications of any sexually transmitted disease	☐	☐
75. Malignant disease of the bladder, kidney, ureter, prostate, testicles, etc.	☐	☐

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

	YES	NO
URINARY SYSTEM		
76. Missing a kidney	☐	☐
77. Renal transplant	☐	☐
78. Kidney stone, infection, or disease	☐	☐
79. Kidney or urinary tract surgery	☐	☐
80. Painful or difficult urination	☐	☐
81. Blood or protein in urine	☐	☐
SPINE AND SACROILIAC JOINTS		
82. Recurrent back pain or back problem	☐	☐
83. Herniated disk	☐	☐
84. Recurrent neck pain	☐	☐
85. Back or neck surgery	☐	☐
86. Abnormal curvature of spine (any part)	☐	☐
UPPER EXTREMITIES		
87. Painful shoulder, elbow, wrist, hand, or fingers	☐	☐
88. Dislocated shoulder, elbow, wrist, hand, or fingers	☐	☐
LOWER EXTREMITIES		
89. Foot trouble (i.e. painful bunions, warts, ingrown toenails, etc.)	☐	☐
90. Knee trouble (i.e. locking, giving out, or ligament injury, etc.)	☐	☐
91. Painful hip, knee, ankle, foot or toes	☐	☐
92. Dislocated hip, knee, foot, or toes	☐	☐
MISCELLANEOUS CONDITIONS OF THE EXTREMITIES		
93. Bone, joint, or other orthopedic deformity	☐	☐
94. Loss of finger or toe, or extra finger or toe	☐	☐
95. Loss of the ability to fully flex (bend) or fully extend a finger, toe, or other joint	☐	☐
96. Impaired use of arms, hands, legs, or feet (any reason)	☐	☐
97. Arthritis, rheumatism, or bursitis	☐	☐
98. Any swollen joint(s) or gout	☐	☐
99. Surgery on any joint/bone (including arthroscopy)	☐	☐
100. Plate(s), screw(s), rod(s) or pin(s) in any bone	☐	☐
101. Pain or swelling at the site of an old fracture	☐	☐
102. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics	☐	☐
103. Any other orthopedic, muscle, or sports injury problems	☐	☐
104. Physical therapy within the last two years	☐	☐
VASCULAR		
105. High or low blood pressure	☐	☐
106. Raynaud's phenomenon or disease	☐	☐
107. Deep Vein Thrombosis (blood clot; leg or elsewhere)	☐	☐
108. Pulmonary embolism (blood clot in lung)	☐	☐

	YES	NO
SKIN AND CELLULAR		
109. Acne or psoriasis requiring prescription medication within the last two years	☐	☐
110. Eczema	☐	☐
111. Atopic dermatitis (after age 12)	☐	☐
112. Large or painful scars	☐	☐
113. Any other skin problems	☐	☐
BLOOD AND BLOOD FORMING TISSUES		
114. Anemia	☐	☐
115. Any other blood or circulation problems	☐	☐
SYSTEMIC		
116. Tuberculosis	☐	☐
117. Positive test for tuberculosis (PPD or blood test) *If yes, when _____	☐	☐
118. Taken immunosuppressive drugs within the past year (steroids, chemotherapy, etc.)	☐	☐
119. Disorder(s) of immune system (including HIV)	☐	☐
120. Car, train, sea, or air sickness	☐	☐
ENDOCRINE AND METABOLIC		
121. Thyroid disorder or goiter	☐	☐
122. High or low blood sugar	☐	☐
123. Diabetes	☐	☐
NEUROLOGIC		
124. Cerebrovascular accident (stroke)	☐	☐
125. Skull fracture	☐	☐
126. Severe headaches to include migraines	☐	☐
127. Lost time from work or school due to frequent or severe headaches	☐	☐
128. A head injury, memory loss, or amnesia or Traumatic Brain Injury (TBI)	☐	☐
129. A period of unconsciousness or concussion	☐	☐
130. Seizures, convulsions, epilepsy or fits	☐	☐
131. Meningitis, encephalitis, or other neurological problems	☐	☐
132. Paralysis	☐	☐
133. Dizziness or fainting spells	☐	☐
134. Any other neurologic problems	☐	☐
SLEEP DISORDERS		
135. Sleepwalking or narcolepsy	☐	☐
136. Frequent trouble sleeping/Insomnia	☐	☐
137. Sleep Apnea	☐	☐
138. Use of CPAP*If yes, please submit CPAP compliance data for a minimum of 30 days	☐	☐
LEARNING, PSYCHIATRIC, BEHAVIORAL		
139. Evaluated or treated for Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)	☐	☐
140. Taken (or taking) medication(s), drugs, or any substance to improve attention, behavior, or physical performance	☐	☐
141. Diagnosed with a learning disorder, to include dyslexia	☐	☐

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

LEARNING, PSYCHIATRIC, BEHAVIORAL (cont'd)	**YES**	**NO**
142. Seen a psychiatrist, psychologist, social worker, counselor, or other professional for any reason (inpatient or outpatient) including counseling or treatment for school, adjustment, family, marriage, divorce, depression, anxiety, or treatment of alcohol, drug, or substance abuse	☐	☐
143. Been evaluated or treated, either with medication or counseling, for a mental condition (i.e. depression, or excessive worry, etc.)	☐	☐
144. Been expelled or suspended from school	☐	☐
145. Anorexia, bulimia, or other eating disorder	☐	☐
146. Habitual stammering or stuttering	☐	☐
147. Have you ever purposely cut or harmed yourself	☐	☐
148. Have you ever attempted or considered suicide *If yes, when:	☐	☐
149. Used illegal drugs or abused prescription drugs	☐	☐
150. Have you been evaluated, treated, or hospitalized for substance abuse, addiction or dependence (including illegal drugs, prescription medications or other substances)	☐	☐
151. Have you been evaluated, treated, or hospitalized for alcohol abuse, dependence, or addiction	☐	☐
152. Have you ever been diagnosed with Post-Traumatic Stress Disorder (PTSD)	☐	☐
153. Any other learning, psychiatric, or behavioral problems	☐	☐
TUMORS AND MALIGNANCIES		
154. Tumor, growth, cyst, or cancer of any type	☐	☐
MISCELLANOUS		
155. Cold injury, frostbite, or cold intolerance	☐	☐
156. Heat injury, heat stroke, or heat intolerance	☐	☐
157. Have you ever had, or are you currently being treated for any other illness or injury not already mentioned *If yes, provide details and dates on page 6	☐	☐
158. Have you ever smoked *If yes, complete the following ☐ Current ☐ Past Type: ☐ Cigarettes ☐ Cigars ☐ Pipe How many per day: _____ How long: _____	☐	☐
159. Alcohol Use *If yes, complete the following Number of drinks per week/month _____ (Scale: 1 drink - 12 oz. beer, 1 glass of wine, 1.5 oz. liquor) When do you drink alcohol? ☐ Weekday ☐ Weekend ☐ Both	☐	☐

*****END OF MEDICAL HISTORY QUESTIONNAIRE.*****

REMEMBER TO PROVIDE A DETAILED EXPLANATION OF ALL "YES" RESPONSES ON PAGE 7.

Please bring the following with you to your appointment:

1. **For ANY medical condition(s) for which you have been evaluated within the last two years, please bring clinical treatment records.**
2. **For ANY surgical procedures or orthopedic injuries within the past three years, please bring treatment records, operative reports, and any physical therapy discharge summaries**
3. **For ANY mental health conditions treated within the past five years, or for which there is a current disability rating, please bring mental health treatment records for the past two years or treatment records after the award of the disability rating**

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

SELECTEE AND EXAMINER COMMENTS
(Selectee and Examiner to Complete This Section)

For all "yes" answers from prior pages, explain in detail. If additional sheet is needed, use page 6a at end of form.

SELECTEE			EXAMINER
Question Number	Date of Injury/Date of Diagnosis (month/year)	Explain in detail the diagnosis, how injury/illness occurred, symptoms, body part affected, type of treatment, current symptoms, etc.	Examiner's Comments

Health care professionals and examiners: Please avoid adding PII in comments.

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

FITNESS QUESTIONNAIRE

(Selectee to Complete This Section)

BEFORE answering the following, please read the Practical Exercise Performance Requirements (PEPR) you received from the Dallas Service Center which was included in the Employment Information Booklet. If there are ANY physical tasks or training exercises on the PEPR that you currently CANNOT perform, list them below.

1. Are you familiar with the physical requirement of the position for which you applied? ☐ Yes ☐ No

2. Are you capable of performing the following?

Vigorous aerobic activity at least 3 hours/week	☐ Yes	☐ No
1 ½ mile time run	☐ Yes	☐ No
¼ mile run	☐ Yes	☐ No
Quickly get in/out of mid-sized car with ease	☐ Yes	☐ No
Squat or kneel for up to 45 seconds repeatedly	☐ Yes	☐ No
Kneel for 2-3 minutes at a time repeatedly	☐ Yes	☐ No

3. Do you have any lifting restrictions? ☐ Yes ☐ No

If yes, what is the maximum number of pounds you are allowed to lift _____ lbs.

Selectee's Comments: If you indicated that you are **INCAPABLE** of performing one of the activities in question 2 above, please provide an explanation below: ☐ N/A

Examiner's Comments: ☐ N/A

I certify that all of the information I have provided on this form is complete and accurate to the best of my knowledge, and that submitting information that is incomplete, misleading, or untruthful may result in termination, criminal sanctions, or delays in processing this form for employment. Furthermore, consistent with the Privacy Act Statement, I authorize the release to my employing agency of all information contained on this examination from and all other forms generated as a direct result of my examination.

SELECTEE MUST SIGN BELOW IN THE PRESENCE OF A WITNESS FROM THE EXAMINING FACILITY.

SELECTEE'S SIGNATURE	DATE:

WITNESS SIGNATURE	DATE:

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

VISION TESTING
(Examiner to complete This Section)

DEPTH PERCEPTION

Check Test Used:

☐ **Titmus Stereo** ☐ **Titmus Vision Screener** ☐ **Other**

_____ of _____ total number

Document the number of correct responses above.

_____ Seconds of Arc

OR

_____ % Shepard-Fry

PERIPHERAL VISION

Right	***Left***
Temporal _____ ° Normal: 70-90° **Total** _____ ° Nasal _____ ° Normal: 30-60°	Temporal _____ ° Normal: 70-90° **Total** _____ ° Nasal _____ ° Normal: 30-60°

VISUAL ACUITY TESTING

1. Does the selectee wear soft contact lenses (SCLs)?
   - ☐ Yes
   - ☐ No
2. If yes, has the selectee successfully worn SCLs for at least six weeks?
   - ☐ Yes (If yes, test CORRECTED vision only)
   - ☐ No (If no, test UNCORRECTED and CORRECTED vision)

UNCORRECTED VISION (Snellen Units)				***CORRECTED VISION (Snellen Units)***			
FAR	Both 20/ _____	Right 20/ _____	Left 20/ _____	**FAR**	Both 20/ _____	Right 20/ _____	Left 20/ _____
NEAR	Both 20/ _____	Right 20/ _____	Left 20/ _____	**NEAR**	Both 20/ _____	Right 20/ _____	Left 20/ _____

COLOR VISION-HARDY, RAND, AND RITTLER (HRR)

If near visual acuity is 20/30 or better without corrective lenses, then color vision testing should be conducted without corrective lenses

Number of Correct Responses _____ of _____ **(ATTACH HRR COLOR VISION SCORE SHEET)**

Printed Name of Examiner	Signature of Examiner	Date	Telephone Number

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

AUDIOLOGY
(Examiner to complete This Section)

DO NOT TEST WITH HEARING AIDS

Right Ear

Canal/external ear: ☐ Normal ☐ Abnormal (if abnormal, describe)

Tympanic/membrane: ☐ Normal ☐ Abnormal (if abnormal, describe)

Left Ear

Canal/external ear: ☐ Normal ☐ Abnormal (if abnormal, describe)

Tympanic/membrane: ☐ Normal ☐ Abnormal (if abnormal, describe)

Daily Calibration Method: ☐ Oscar (machine) ☐ Biological (person)

Yearly Calibration Date:

Frequency	**500 Hz**	**1000 Hz**	**2000 Hz**	**3000 Hz**	**4000 Hz**	**6000 Hz**
Right Ear						
Left Ear						

BODY MEASUREMENTS
(Examiner to Complete This Section)

Height: _____ inches (without shoes)

Weight: _____ pounds (without shoes)

VITAL SIGNS
(Examiner to Complete This Section)

Readings	**Pulse**	**Blood Pressure**
Initial Reading	_____	_____
Repeat Reading	_____ If initial pulse ≥ 100; wait 15 minutes and recheck	_____ If initial BP ≥ 140/90; wait 15 minutes and recheck

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

ORTHOPEDIC CLINICAL EVALUATION
(Examiner to Complete this Section)

Check each item in appropriate column	Normal (No)	Abnormal (Yes)	Check each item in appropriate column	Normal (No)	Abnormal (Yes)
Upper extremities			**Lower Extremities**		
Shoulder, Elbow, Wrist			Hip, Knee, Ankle, Feet		
Range of motion/flexibility	☐	☐	Range of motion/flexibility	☐	☐
Strength/Stability	☐	☐	Strength/Stability	☐	☐
Tenderness to palpation	☐	☐	Tenderness to palpation	☐	☐
Pain with motion	☐	☐	Pain with motion	☐	☐
Hand/Fingers			**Spine**		
Range of motion/flexibility	☐	☐	Upper Back/Neck		
Strength/Stability	☐	☐	Range of motion/flexibility	☐	☐
Tenderness to palpation	☐	☐	Strength/Stability	☐	☐
Pain with motion	☐	☐	Tenderness to palpation	☐	☐
Hand Dexterity	☐	☐	Pain with motion	☐	☐
			Low Back		
			Range of motion/flexibility	☐	☐
			Strength/Stability	☐	☐
			Tenderness to palpation	☐	☐
			Pain with motion	☐	☐

**** EXPLAIN **ALL** ABNORMAL ORTHOPEDIC FINDINGS FOUND ABOVE ON PAGE 11 AND 12 (USE ADDITIONAL PAGES IF NEEDED)*

Functional Screening Evaluation **(Examiner to Complete this Section)**

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

(Examiner to Complete This Section)

If ANY orthopedic injury or condition has occurred, document the following for each injury. Use additional paper if necessary.

Issue #1: Type of injury/condition (back strain, ankle sprain, carpal tunnel, etc.): _____

How did the injury/condition occur?

Date of injury/diagnosis

Describe treatment, including approximate dates

Did the selectee lose time from work/school?

Have all symptoms resolved? If so, when? If not, describe current symptoms, frequency, and when they occur.

Does the selectee report any current restrictions or limitations because of this issue? If so, describe.

Does the selectee report any residual symptoms with exercise (e.g., pain, swelling, exercise intolerance, etc.)?

Additional comments:

Based on your physical exam, does the selectee appear to have limitations because of this issue? ☐ Yes ☐ No

Issue #2: Type of injury/condition (back strain, ankle sprain, carpal tunnel, etc.): _____

How did the injury/condition occur?

Date of injury/diagnosis

Describe treatment, including approximate dates

Did the selectee lose time from work/school?

Have all symptoms resolved? If so, when? If not, describe current symptoms, frequency, and when they occur.

Does the selectee report any current restrictions or limitations because of this issue? If so, describe.

Does the selectee report any residual symptoms with exercise (e.g., pain, swelling, exercise intolerance, etc.)?

Additional comments:

Based on your physical exam, does the selectee appear to have limitations because of this issue? ☐ Yes ☐ No

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

(Examiner to Complete This Section)

If ANY orthopedic injury has occurred, document the following for each injury. Use additional paper if necessary.

Issue #3: Type of injury/condition (back strain, ankle sprain, carpal tunnel, etc.): _____

How did the injury/condition occur?

Date of injury/diagnosis

Describe treatment, including approximate dates

Did the selectee lose time from work/school?

Have all symptoms resolved? If so, when? If not, describe current symptoms, frequency, and when they occur.

Does the selectee report any current restrictions or limitations because of this issue? If so, describe.

Does the selectee report any residual symptoms with exercise (e.g., pain, swelling, exercise intolerance, etc.)?

Additional comments:

Based on your physical exam, does the selectee appear to have limitations because of this issue? ☐ Yes ☐ No

Issue #4: Type of injury/condition (back strain, ankle sprain, carpal tunnel, etc.): _____

How did the injury/condition occur?

Date of injury/diagnosis

Describe treatment, including approximate dates

Did the selectee lose time from work/school?

Have all symptoms resolved? If so, when? If not, describe current symptoms, frequency, and when they occur.

Does the selectee report any current restrictions or limitations because of this issue? If so, describe.

Does the selectee report any residual symptoms with exercise (e.g., pain, swelling, exercise intolerance, etc.)?

Additional comments:

Based on your physical exam, does the selectee appear to have limitations because of this issue? ☐ Yes ☐ No

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

CLINICAL EVALUATION

(Examiner to Complete this Section)

Check each item in appropriate column	Normal	Abnormal
Head, face, neck, and scalp (include thyroid)	☐	☐
Nose	☐	☐
Sinuses	☐	☐
Mouth and throat	☐	☐
Ears-General, ear drums	☐	☐
Eyes, General, pupils, ocular, motility, nystagmus	☐	☐
Heart (rhythm, sounds, murmur)	☐	☐
EKG Interpretation	☐	☐
Lungs and chest	☐	☐
Vascular System (Varicosities)	☐	☐
Abdomen and viscera	☐	☐
Hernia	☐	☐
Identifying body marks, scars, unique markings other than tattoos	☐	☐
Skin, lymphatics	☐	☐
Neurologic	☐	☐

*****NOTE **ALL** ABNORMAL FINDINGS BELOW*

EXAMINER'S SUMMARY OF SIGNIFICANT MEDICAL FINDINGS AND RECOMMENDATIONS

NOTES: *Describe every abnormality if not already described on previous page(s). Describe in detail, based on history, and exam. Use additional sheets if necessary.*

I have reviewed and discussed the medical history with the selectee. Based on my review of the physical examination findings, to include blood pressure and EKG interpretation, it is my opinion that the selectee is CLEARED to complete the fitness step test.

☐ **YES** ☐ **No (If no, explain above)**

NAME OF EXAMINER: (Please print or type.) ☐ **MD** ☐ **DO** ☐ **NP** ☐ **PA (requires co-signature)**

EXAMINER'S SIGNATURE: **DATE:**

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

ICE PRE-EMPLOYMENT TUBERCULOSIS SYMPTOM SCREENING QUESTIONNAIRE

This form is to be used in lieu of TB screening testing for pre-employment. Examiners must ensure that individuals under consideration for a position with ICE are free of highly contagious diseases, such as active tuberculosis, that could endanger the health of other persons.

Part A should be completed by the individual. *A healthcare professional must evaluate the answers and assign a recommendation* in *Part B.*

PART A

1. Have you experienced any of the following symptoms in the past year?

a) A productive cough for more than 3 weeks?	☐ Yes	☐ No
b) Hemoptysis (coughing up blood)?	☐ Yes	☐ No
c) Unexplained weight loss?	☐ Yes	☐ No
d) Fever, chills, or night sweats for no known reason?	☐ Yes	☐ No
e) Persistent shortness of breath?	☐ Yes	☐ No
f) Unexplained fatigue?	☐ Yes	☐ No
g) Chest pain?	☐ Yes	☐ No
2. Have you had contact with anyone with active tuberculosis disease in the past year?	☐ Yes	☐ No
3. Do you have a medical condition, or are you taking medications, which suppress your immune system?	☐ Yes	☐ No

Please provide details to any questions answered "Yes" above.

I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.

Signature	Printed Name	Date

PART B

Upon review of the responses to the questionnaire and discussion with the person for whom the tuberculosis evaluation is required, I recommend as follows:

☐ There is no indication this person has active tuberculosis at this time.

☐ Examiner notes regarding any "Yes" responses:

☐ Further evaluation, including a TB Skin Test or other medical evaluation is indicated, and should be completed prior to employment.

Healthcare Professional Signature	Printed Name	Date

SELECTEE'S NAME:	SSN/ID NUMBER:	DATE:

SELECTEE AND EXAMINER COMMENTS

(Selectee and Examiner to Complete This Section)

For all "yes" answers from prior pages, explain in detail. Use additional sheets if needed.

SELECTEE			EXAMINER
Question Number	Date of Injury/Date of Diagnosis (month/year)	Explain in detail the diagnosis, how injury/illness occurred, symptoms, body part affected, type of treatment, current symptoms, etc.	Examiner's Comments