

**\*\*\*UPDATE\*\*\***

The NOAA Health Services questionnaire that was presented at the 2002 Annual RVOC Meeting has been updated. For the latest information please visit the NOAA Website at: [www.oma.noaa.gov](http://www.oma.noaa.gov).

The newest version (Apr 04) of the NOAA Health Services Questionnaire can be found at: <http://www.oma.noaa.gov/pdf/files/nhsq2003.pdf>

NHSQ

NOAA Health Services  
Questionnaire

CDR TJ Edwards, USPHS  
RDHS/ PMC/NOAA

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N - NOAA

H - Health

S - Services

Q - Questionnaire

# Purpose of the NHSQ

- "... Health records adequate for required medical screening and medical care while underway ... "

NFMPPM Chap 7.2.a.4

- determine health care status
- ensure no harm to individual, crew or mission
- the vessel has reasonable capability to treat

# INDIVIDUAL CONSIDERATIONS

- Quality and Accuracy of Information
- Frequency of Submission
  - biennially for individuals under 50
  - annually for individuals over 50
  - **always needs to be current**
- Review of Information
  - discussion/accommodation with patient and/or ship
- Dissemination of Information; Copies maintained
  - on board the vessel
  - at the marine center
  - MAS (Medical Advice at Sea)
- Returned or destroyed after one year

# VESSEL CONSIDERATIONS

- Vessels Capabilities
  - Level of Medication
  - Level of Equipment
  - Level of Practitioner (minimum stds MPIC)
  - Support (MAS)
  - Length and Location of Cruise
  - Communication Capability of Vessel
  - Evacuation Capability of Vessel
- Cost
- Standards of Care
  - Professional Practice
  - Policy and Procedure Manuals (Navy/MSC/NOAA)
  - Community Standards

## Guidelines

### Scientists and other Embarked Personnel shall;

- completed health questionnaire with current immunizations
  - in accordance with NOAA Policy
  - CDC Guidelines

Chap 4.7, 7.2.a.4

- submit directly to the ships HSO (or designate) at least seven days prior to sailing;  
(may not be timely if individual NFFD, submit early)
- send in an envelope marked "*Confidential – Medical Records*" or via electronic mail (treated as a Privacy Act document)

# NOAA IMMUNIZATIONS STANDARDS

## Required

-Measles, Mumps, Rubella (MMR) **REQUIRED**  
(single dose after age 12)

-PPD **REQUIRED**  
(annual)

-Tetanus/Diphtheria **REQUIRED**  
(q 10 years or with wound)



# NOAA IMMUNIZATIONS STANDARDS

## Recommended

- Cholera (country specific)
- Hepatitis A (foreign ports; endemic areas)
- Hepatitis B (all divers, three shots over a year)
- Influenza (annual)
- Malaria (1-2 wks pre, 4 wks post, resistant strain, (must know G6PD status))
- Meningococcal (known area of outbreak)
- Pneumococcal (usually older or immune suppressed)
- Polio (country specific)
- Rabies (in known or suspected exposure)
- Typhoid Fever (country specific)
- Varicella (Chicken Pox) (consider history)
- Yellow Fever (country specific, vaccinations centers)

# NOAA IMMUNIZATIONS STANDARDS

## *NOT Recommended*

- Anthrax
- JEV (Japanese Encephalitis Virus)
- Plague

## IMMUNIZATION RECORD

- Immunization Record (along with passport)
  - keep and maintain your record
- Current recommendations and by country vaccination requirements can be found on the Centers for Disease Control and Prevention (CDC) Web Site:
  - <http://www.cdc.gov/travel/>
  - or
  - CDC Fax Information Service: (404) 332-4565

# NHSQ EVALUATION

- Health Services Officer (HSO)
  - Ships Master
  - RDHS (by request or default)
- if additional information is required, the individual (or organization) will be notified. The individual may be precluded from embarking until found fit for sea duty
- again 7 days may not be enough time

## Evaluation Outcomes

- If determined not fit for sea duty, the RDHS will specify what accommodation is necessary
- The individual and/or the sponsoring organization will be notified by the RDHS of the necessary accommodation
- The sponsoring organization responsible for providing the required accommodation

# Financial Responsibility

- All scientific personnel brought on board at sea for any reason may be given medical care on board regardless of entitlement or non- entitlement
- Payment for **medical evacuation** of scientific personnel embarked on NOAA ships will remain the responsibility of the individual, his/her insurance program, or his/her agency, employer, etc.
- Payment for **medical referral** of scientific personnel embarked on NOAA vessels will remain the responsibility of the individual, his/her insurance program, or his/her agency, employer, etc.

## NHSQ COMPONENTS

- Identifying Information
- General Health Information
- General Screening
- Cardiac Screening
- Immunization Screening
- Cruise and Clearance Information

# NHSQ

## IDENTIFYING INFORMATION

Name \_\_\_\_\_  
Last First MI Program \_\_\_\_\_

Position \_\_\_\_\_

Birth Date \_\_\_/\_\_\_/\_\_\_ ( mm/dd/yy) Sex: Male Female

Work Address  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone  
W (\_\_\_\_\_) \_\_\_\_\_  
H (\_\_\_\_\_) \_\_\_\_\_



## HEALTH INFORMATION

General State of Health:      Excellent ?    Good ?    Fair ?    Poor ?

Presently under the care of a physician?    No ?    Yes ?

Month/Year of most recent Physical Exam?      \_\_\_ / \_\_\_

List current medications (prescription and non-prescription):

None ?	1. _____	4. _____
	2. _____	5. _____
	3. _____	6. _____

List Allergies :	Allergy	Reaction
None ?	1. _____	_____
	2. _____	_____
	3. _____	_____
	4. _____	_____

List ALL active health problems:

None ?	1. _____
	2. _____
	3. _____
	4. _____

Major Surgeries / Hospitalizations / Emergency Room visits

	Year	Reason
None ?	1. _____	_____
	2. _____	_____
	3. _____	_____
	4. _____	_____

List Any Dietary Restrictions:

	Restriction	Reason
None ?	1. _____	_____
	2. _____	_____

## GENERAL SCREENING

As an adult, have you had or experienced?

	No	Yes		No	Yes
Cancer	?	?	Severe Depression	?	?
Tuberculosis	?	?	Paralysis	?	?
Asthma	?	?	Epilepsy	?	?
Hepatitis	?	?	Impaired Mobility	?	?
Chronic Cough	?	?	Severe Hearing Loss	?	?
Coughed up Blood	?	?	Severe Visual Impairment	?	?
Recent unexplained gain or loss of 20 or more lbs.	?	?	Periods of Unconsciousness	?	?
			Severe Motion Sickness	?	?

Please explain all YES answers:

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## CARDIAC SCREENING

As an adult, have you had or experienced?

	No	Yes		No	Yes	(and value if known)
Abnormal ECG	?	?	Hypertension	?	?	recent reading _____
Sedentary Life Style	?	?	Diabetes	?	?	HgA <sub>1C</sub> _____
Family History of Heart	?	?	High Cholesterol	?	?	recent reading _____
Attack before age 45	?	?	Tobacco Use	?	?	packs/day _____
Heart Attack	?	?	Prolonged Chest Pain	?	?	
Shortness of Breath	?	?	Fainting spells/Syncope	?	?	

Please explain all YES answers:

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## IMMUNIZATION SCREENING

Please list the date(s) you obtained immunizations/prophylaxis against the following diseases:

	Date	Type	Date Unknown	None
Cholera	_____		?	?
Diphtheria <sup>1</sup>	_____		?	?
Hepatitis A Series:	Dose 1 _____		?	?
	Dose 2 _____		?	?
Hepatitis B Series:	Dose 1 _____		?	?
	Dose 2 _____		?	?
	Dose 3 _____		?	?
Influenza (most recent only)	_____		?	?
Immunoglobulin (IG)	_____		?	?
Malaria	_____	_____	?	?
Measles, Mumps, Rubella (MMR)	_____		?	?
Pneumococcal pneumonia	_____		?	?
Polio	_____	_____	?	?
Rabies	_____		?	?
Tetanus <sup>1</sup>	_____		?	?
Typhoid Fever	_____		?	?
Yellow Fever	_____		?	?
Other: Please provide complete information on Continuation Sheet				

<sup>1</sup>May be given as part of TD vaccination

Are you aware of any other medical condition(s) that may effect your suitability for sea duty?    No ?    Yes ?

If yes, please explain on the continuation: \_\_\_\_\_  
 \_\_\_\_\_

If you have any questions, please contact the appropriate Health Services Office:

**Atlantic Marine Center (757) 441-6320**

**Pacific Marine Center (206) 553-8704**

Continuation page attached? No ? Yes ?

The information provided is complete to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (mm/dd/yy)

For the following cruise dates:

1. Ship _____	cruise dates _____
2. Ship _____	cruise dates _____
3. Ship _____	cruise dates _____

**MEDICALLY CLEARED FOR SEA DUTY BY HISTORY**    YES ?    NO ?    NEED MORE INFO ?

\_\_\_\_\_  
AMC / PMC Regional Director of Health Services

\_\_\_\_\_  
Date (mm/dd/yy)

# NHSQ Web Site

- <http://www.oma.noaa.gov/oma/>
- MOCDOCS (link)
- forms (63.)
- NOAA Health Services Questionnaire

# Common Disqualification's

- Asthma with Hospitalization
- Severe Sea Sickness
- Renal Calculi
- Recent Surgery
- Missing sections or pages
- Psycotropic medication
  
- Chronic Diseases (Cardiac, DM, Seizures, Migraines)

# Standards

- Medical standards for wage marine employees, general schedule, electronic technicians, scientists and other embarked personnel are identified in the NFMPM (Chapter 5) and the NFMPM Appendix.



## FINAL THOUGHTS

- Biological Monitoring Program
  - for crew and scientists
  - exposure based
- What comes on with the Scientists goes off with the Scientists
- MAS calls I receive
  - only routine
  - most from ships without medical personnel
- I disqualify very few scientists

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# NOAA Health Service Questionnaire

## GENERAL SCREENING

As an adult, have you had or experienced?

	No	Yes		No	Yes
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Severe Depression	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Impaired Mobility	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Severe Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Coughed up Blood	<input type="checkbox"/>	<input type="checkbox"/>	Severe Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Recent unexplained gain or loss of 20 or more lbs.	<input type="checkbox"/>	<input type="checkbox"/>	Periods of Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>
			Severe Motion Sickness	<input type="checkbox"/>	<input type="checkbox"/>

Please explain all YES answers:

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## CARDIAC SCREENING

As an adult, have you had or experienced?

	No	Yes		No	Yes	
Abnormal ECG	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	(and value if known) recent reading _____
Sedentary Life Style	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	HgA <sub>1c</sub> _____
Family History of Heart	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	recent reading _____
Attack before age 45	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	packs/day _____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells/Syncope	<input type="checkbox"/>	<input type="checkbox"/>	

Please explain all YES answers:

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	Date	Type	Date Unknown	None
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	Dose 2 _____		<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B Series:	Dose 1 _____		<input type="checkbox"/>	<input type="checkbox"/>
	Dose 2 _____		<input type="checkbox"/>	<input type="checkbox"/>
	Dose 3 _____		<input type="checkbox"/>	<input type="checkbox"/>
Influenza (most recent only)	_____		<input type="checkbox"/>	<input type="checkbox"/>
Immunoglobulin (IG)	_____		<input type="checkbox"/>	<input type="checkbox"/>
Malaria	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Measles, Mumps, Rubella (MMR)	_____		<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal pneumonia	_____		<input type="checkbox"/>	<input type="checkbox"/>
Polio	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Rabies	_____		<input type="checkbox"/>	<input type="checkbox"/>
Tetanus <sup>1</sup>	_____		<input type="checkbox"/>	<input type="checkbox"/>
Typhoid Fever	_____		<input type="checkbox"/>	<input type="checkbox"/>
Yellow Fever	_____		<input type="checkbox"/>	<input type="checkbox"/>
Other: Please provide complete information on Continuation Sheet				

<sup>1</sup>May be given as part of TD vaccination

Are you aware of any other medical condition(s) that may effect your suitability for sea duty? No  Yes

If yes, please explain on the continuation: \_\_\_\_\_  
 \_\_\_\_\_

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Signature

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Date (mm/dd/yy)

For the following cruise dates:

1. Ship _____	cruise dates _____
2. Ship _____	cruise dates _____
3. Ship _____	cruise dates _____

**MEDICALLY CLEARED FOR SEA DUTY BY HISTORY** YES  NO  NEED MORE INFO

\_\_\_\_\_  
AMC / PMC Regional Director of Health Services

\_\_\_\_\_  
Date (mm/dd/yy)