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BSOB MEDICAL SURVEILLANCE

NYS Department of Health

Section II. Interval History

Patient's Name_____ SS#_____

Employer_____ Date of Birth:_____

Date of Exam:_____

During the past 8 or 9 months, since your first exposure to the Binghamton State Office Building (BSOB) after the fire, (Feb. 5, 1981), have you have any of the following:

		YES	NO	UNKNOWN
		(If yes, provide specific details on comment page)		
1.	Excessive weight loss (10 lbs. or more)	☐	☐	☐
2.	Excessive weakness	☐	☐	☐
3.	Itching of the skin	☐	☐	☐
4.	Changes in coloration of the skin	☐	☐	☐
5.	Thickening or scaling of the skin	☐	☐	☐
6.	Acne	☐	☐	☐
7.	Inflamation of sweat glands	☐	☐	☐
8.	Rash or dermatitis	☐	☐	☐
9.	Headaches	☐	☐	☐
10.	Dizziness	☐	☐	☐
11.	Discharge or infection of the eye	☐	☐	☐
12.	Swelling of eyelids	☐	☐	☐
13.	Burning or pain in eyes	☐	☐	☐
14.	Changes in vision	☐	☐	☐
15.	Frequent coughing	☐	☐	☐
16.	Trouble with breathing	☐	☐	☐
17.	Heart trouble	☐	☐	☐
18.	Loss of appetite	☐	☐	☐
19.	Pain in abdomen	☐	☐	☐
20.	Nausea or vomiting	☐	☐	☐
21.	Changes in bowel habits	☐	☐	☐
22.	Jaundice	☐	☐	☐
23.	Hepatitis or liver problems	☐	☐	☐

SS#_____

Patient's Name_____

Interval History (continued)

		YES	NO	UNKNOWN (If yes, provide specific details on comment page)
24.	Trouble with urination	☐	☐	☐
25.	Abnormality in menstrual cycle (female only)	☐	☐	☐
26.	Pregnancy (females and wives of male workers)	☐	☐	☐
27.	Difficulty becoming pregnant (females and wives of males)	☐	☐	☐
28.	Numbness in the extremities	☐	☐	☐
29.	Muscle pain	☐	☐	☐
30.	Clumsiness of movement	☐	☐	☐
31.	Hearing difficulties	☐	☐	☐
32.	Nervousness or sleep problems	☐	☐	☐
33.	Cancer of any type	☐	☐	☐
34.	Other noteworthy symptoms or illnesses	☐	☐	☐

Please specify_____

_____

_____

COMMENT PAGE

SS#_____

Patient's Name_____

(1) Complaint Number_____

(2) Describe the Complaint in Greater Detail_____

_____

_____

_____

_____

_____

_____

_____

(3) Duration of Complaint _____/_____ _____/_____

From (Month - Year) To (Month - Year)

(4) Was Patient Seen by a Physician Yes ☐ No ☐

If yes -

A. Name of Physician_____

B. Physician's Address_____

C. Was a Diagnosis Established Yes ☐ No ☐ Don't Recall ☐

If yes, what was the Diagnosis

D. Was Patient Hospitalized Yes ☐ No ☐

If yes, Name of Hospital _____

Address_____

Date of Admission_____

Section III. PHYSICAL EXAMINATION

Patients Name:_____ Social Security #:_____

Employer:_____ Date of Birth:_____

Date of Exam:_____

1. (a) Height (in.) _____ (b) Weight (lbs.)_____ (c) Temp. _____
   (d) Pulse_____ (e) Resp._____ (f) BP____/____
   (g) Visual Acuity R____/____ L____/____

2. General Appearance: ☐ Well ☐ Ill or Distressed
   ☐ Male ☐ Female ☐ White ☐ Black ☐ Other

3. Skin - specify if the following are present — Nl ☐ Abn ☐

	Yes	No		Yes	No
a. Erythema	☐	☐	g. Hyperpigmentation	☐	☐
b. Rash	☐	☐	h. Thickening	☐	☐
c. Acne-like lesions	☐	☐	i. Nail discoloration	☐	☐
d. Depigmentation	☐	☐	j. Jaundice	☐	☐
e. Inclusion cysts	☐	☐	k. Spider angiomata	☐	☐
f. Petechiae	☐	☐	l. Ecchymosis	☐	☐
			m. Other	☐	☐

Specify:_____

_____

_____

If yes for a-m, specify location and describe in detail:_____

_____

_____

_____

4. Eyes - Nl ☐ Abn ☐

	Yes	No
a. Conjunc. injection	☐	☐
b. Eye discharge	☐	☐
c. Swelling of lids	☐	☐
d. Abnormal pigment	☐	☐
e. Other	☐	☐

Specify:_____

5. Liver and Abdomen — Nl ☐ Abn ☐

	Yes	No	
a. Hepatomegaly	☐	☐	_____cm. liver span
b. Tenderness	☐	☐	
c. Other masses	☐	☐	Specify:_____

Physical Exam (Continued)

Patient's Name_____ Social Security #_____

NL ☐ Abn ☐ 6. Neurological

☐ ☐ a. Gait

☐ ☐ b. Muscle strength - specify if decreased:

		Yes	No				
I.	Distal wrist extensors	☐	☐	R	☐	L	☐
II.	Ankle/toe Dors/Flexors	☐	☐	R	☐	L	☐
III.	Deltoids	☐	☐	R	☐	L	☐
IV.	Hip Flexors	☐	☐	R	☐	L	☐
V.	Hip Extensors	☐	☐	R	☐	L	☐

Nl ☐ Abn ☐ c. Abnormal movements ☐ ☐ R ☐ L ☐

Specify:_____

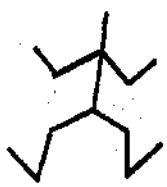
_____

Nl ☐ Abn ☐ d. Coordination

Specify:_____

_____

Nl ☐ Abn ☐ e. Reflexes: Biceps, Triceps, Patellar, Achilles, Babinski indicate on diagram (0-absent, 1-sluggish, 2-active, 3-very active, 4-clonus)



Nl ☐ Abn ☐ f. Sensory system - specify if decreased

		Yes	No				
I.	Touch	☐	☐	R	☐	L	☐
II.	Pin Prick	☐	☐	R	☐	L	☐
III.	Vibration (ankle)	☐	☐	R	☐	L	☐
IV.	Position (great toe)	☐	☐	R	☐	L	☐

If yes for I-IV, specify location_____

Nl ☐ Abn ☐ g. Cranial nerves - specify any abnormalities

_____

Patient's Name_____ Social Security #:_____

Physical Exam (Continued)

Nl	Abn		
☐	☐	7.	Head and neck - specify abnormalities:
☐	☐	8.	Nodes
☐	☐	9.	Breasts
☐	☐	10.	Lungs
☐	☐	11.	Heart
☐	☐	12.	Back
☐	☐	13.	Extremities
☐	☐	14.	Genitalia (pelvic exam. optional)
☐	☐	15.	Rectal

Yes	No		
		16.	Recommendations and/or referrals
☐	☐		a.
☐	☐		b.
☐	☐		c.

Examiner's Signature_____ M.D.

Comments: