

Physical Exam – 4 December 2009

Medical Questionnaire and Exam

Applicant's Name: BOSTER, CHESTER CARL Date of Birth: 5 MAR 47
(Last) (First) (M.I.)

The following must be answered by the applicant in his or her own handwriting:

Applicant: If you answer "yes" to any questions A through E, explain fully on the back side of this form.

	Yes	No
A. Have you ever had or been treated for the following?		
1. Migraine or disabling headaches?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. <u>Bad Vision</u> , color blindness or poor hearing?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Tuberculosis, <u>Hay Fever</u> , asthma, or a lung disorder?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. High blood pressure, heart condition, pain or pressure in the chest?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Diabetes, epilepsy, fainting spells, blackouts, convulsions, or nervous breakdown?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Circulatory ailments, varicose veins?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Disorder of the <u>stomach</u> , ulcers, or gall bladder?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Hemorrhoids or unrepai red hernia?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Any fractures, bone or joint disorder or arthritis?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Back injury, back problems, or back ache?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11. Any other illness, disability, injury, operation or infectious/contagious disease that might prevent you from performing your job?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. Have you ever been in a hospital, clinic, or institution for observation, treatment or operation?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
C. Are you a disabled veteran or handicapped person?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
D. Are you currently on any medications?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
E. Any drug or environmental allergies?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
F. Do you represent yourself to be in good health? If no, explain on the back side of this form.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
G. Do you understand that a false statement or misrepresentation will justify dismissal from service and have other consequences such as loss of benefits, regardless of when such fact may be discovered by the company?	<input checked="" type="checkbox"/>	<input type="checkbox"/>

I certify that the above information is true and complete to the best of my knowledge.
I authorize AHCC to fax or mail this exam to Callup Indian Medical Center
Fax 505-722-1397 Date: 4 DEC 09 Signature of Applicant: [Signature]

Height: 71 in Hearing: W/Wh's
Weight: 192 lbs Heart: NY
B/P: 124/76 Lungs: Clean
Pulse: 60 Abdomen: Soft & Masses
Far Vision: _____ Hernia: None
Glasses/Contacts Yes ___ No ✓ Back: W/Wh's
Eyes: LT. 20/ 25 RT. 20/ 20 Other: None
Healthy Male - no Restrictions

Examiner: [Signature] Date: 12/4/09 Side 1 of 2

Alaska Health Care Clinic
3600 Minnesota Drive, Anchorage, Alaska 99503
907-279-3500, Fax 907-258-0153

Medical Questionnaire and Exam

Applicant's Name: BOSTON, CHESTER CARL Date of Birth: 5/26/47
(Last) (First) (M.I.)

The following must be answered by the applicant in his or her own handwriting:

If you answered "yes" to any questions A through F, please fully explain below.

A:

1. _____
2. Myopia, Lasik bilat circa '98
3. Hay fever - dust, Te & Zyrtec + nasal sprays
4. _____
5. _____
6. _____
7. Gastritis 1990
8. _____
9. _____
10. _____
11. _____

B: Surgeries: Rt rotator cuff repair, Rt trigger thumb releasing bilat. CTR

C: _____

D: Zyrtec, Advant 100, Benzon 100, 9-10-15A

E: PCN Dust, pollen

F: _____

I certify that the above information is true and complete to the best of my knowledge.

Date: 4/11/07 Signature of Applicant: [Signature]

Side 2 of 2