Item ID Number 02292

Author

Corporate Author

Report/Article Title Form: BSOB Medical Surveillance, NYS Department of Health

Journal/Book Title

Year

Month/Day

Color ☐

Number of Images 6

Descripton Notes

14
725RK

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:

(If yes, provide specific details on comment page)

		YES	NO	UNKNOWN
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	☐	☐	☐

CC-323

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	☐	☐	☐
X 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____________________

BSOB MEDICAL SURVEILLANCE - DOH

Section III. PHYSICAL EXAMINATION

Patient's 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

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

	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: ______________________

Nl ☐ Abn ☐ 4. Eyes -

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

Specify: ______________________

Nl ☐ Abn ☐ 5. Liver and Abdomen

	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	R	L
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: ______________________________

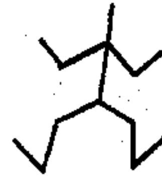
____

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	R	L
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: