



### Medical History & Examination Form for FireFighters

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_M \_\_\_\_F

Fire Department: \_\_\_\_\_

#### Smoking History

This information is needed since tobacco use increases your risk for lung cancer and several other types of cancer, chronic bronchitis, emphysema, asbestos related lung diseases, coronary heart disease, high blood pressure, and stroke.

|                                       |                                                                                                                                                                                                                 |                                                                                                                                                                                                                |
|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Never Smoked | <input type="checkbox"/> Current Smoker<br># cigarettes per day _____<br># of cigars per day _____<br># of pipe bowls per day _____<br>Amt of chewing tobacco per day _____<br>Total years of tobacco use _____ | <input type="checkbox"/> Former Smoker<br># cigarettes per day _____<br># of cigars per day _____<br># of pipe bowls per day _____<br>Amt of chewing tobacco per day _____<br>Total years of tobacco use _____ |
|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

#### Describe your Physical Activity Program

Type of Activity or Exercise \_\_\_\_\_

Intensity \_\_\_\_ Low \_\_\_\_ Moderate \_\_\_\_ High

Duration of minutes per session \_\_\_\_\_ Frequency, in days per week \_\_\_\_\_

#### Immunization Status

Date of last tetanus shot \_\_\_\_\_ Hepatitis B Immunity? \_\_\_\_Yes \_\_\_\_No \_\_\_\_ Unsure

Medication Allergies: \_\_\_\_\_

#### Current Medications

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Summary of your Medical History

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Surgeries

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Other Medical History Questions

Note: for every item noted as "Yes" provide information in the blank to the right.

|                                                                                                                                                                              | Yes/No | If Yes, provide information |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|-----------------------------|
| Have you ever been treated with an organ treated with an organ transplant, prosthetic device (e.g. hip or knee) or an implanted pump (for insulin) or cardiac defibrillator? |        |                             |
| Have you had or have you been advised to have an operation?                                                                                                                  |        |                             |
| Have you ever been an overnight patient at any hospital?                                                                                                                     |        |                             |
| Have you consulted or been treated by clinics, practitioners, healers, within the past year for any other minor illness or injury?                                           |        |                             |
| Have you been rejected for military service?                                                                                                                                 |        |                             |
| <u>Have you ever been treated for a mental health or emotional condition?</u>                                                                                                |        |                             |
| <u>Have you been diagnosed with or treated for alcoholism or alcohol dependence?</u>                                                                                         |        |                             |
| <u>Have you been diagnosed as being dependent on drugs, or treated for drug abuse?</u>                                                                                       |        |                             |
| <u>Have you ever received, is there is pending, or have applied for compensation for a disability?</u>                                                                       |        |                             |

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## REVIEW OF SYSTEMS

### Vision

Do you have or have you had any of the following:

YES NO

|                     |  |  |
|---------------------|--|--|
| Eye Disease         |  |  |
| Wear eye glasses    |  |  |
| Wear contact lenses |  |  |
| Blurred vision      |  |  |
| Difficulty reading  |  |  |
| Glaucoma            |  |  |
| Cataracts           |  |  |
| Color Blindness     |  |  |

Please explain any YES answers below:

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### Hearing

Do you have or have you had any of the following:

YES NO

|                                                                         |  |  |
|-------------------------------------------------------------------------|--|--|
| Ear Disease                                                             |  |  |
| Constant noise in last 14 hr                                            |  |  |
| Loud impact noise in last 14 hr                                         |  |  |
| Ringing in ears or tinnitus                                             |  |  |
| Difficulty hearing                                                      |  |  |
| Ear infection in last 2 weeks                                           |  |  |
| Hearing Aids                                                            |  |  |
| Do you use protective hearing equipment when working around loud noise? |  |  |

Please explain any YES answers below:

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### Vascular

Do you have or have you had any of the following:

YES NO

|                                                |  |  |
|------------------------------------------------|--|--|
| Any vascular disease                           |  |  |
| Enlarged veins, varicose veins or blood clots? |  |  |
| Anemia                                         |  |  |
| Hardening of arteries                          |  |  |
| High blood pressure                            |  |  |
| Stroke or TIA                                  |  |  |
| Aneurysms                                      |  |  |
| Poor circulation to hands and feet             |  |  |
| White fingers with cold or vibration           |  |  |

Please explain any YES answers below:

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### Respiratory

Do you have or have you had any of the following:

YES NO

|                                 |  |  |
|---------------------------------|--|--|
| Any respiratory disease         |  |  |
| Asthma                          |  |  |
| Bronchitis or Emphysema         |  |  |
| Unexplained fatigue             |  |  |
| Use of inhalers                 |  |  |
| Acute or chronic lung infection |  |  |
| Collapsed lung                  |  |  |
| History of Tuberculosis         |  |  |

Please explain any YES answers below:

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## Heart

Do you have or have you had any of the following:

YES NO

|                                                                                                              |  |  |
|--------------------------------------------------------------------------------------------------------------|--|--|
| Any heart disease or murmurs                                                                                 |  |  |
| Chest pain with or without exertion                                                                          |  |  |
| Heart rhythm disturbance or palpitations                                                                     |  |  |
| History of Heart Attack                                                                                      |  |  |
| Organic heart disease including pacemakers, heart block, implanted defibrillator, mitral valve prolapse, WPW |  |  |
| Heart Surgery                                                                                                |  |  |
| Sudden loss of conscious                                                                                     |  |  |

Please explain any YES answers below:

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## Gastrointestinal

Do you have or have you had any of the following:

YES NO

|                                  |  |  |
|----------------------------------|--|--|
| Any GI Disease?                  |  |  |
| Hernias                          |  |  |
| Colostomy                        |  |  |
| Persistent stomach pain or ulcer |  |  |
| Hepatitis or liver disease       |  |  |
| Irritable bowel syndrome         |  |  |
| Rectal bleeding                  |  |  |
| Vomiting                         |  |  |

Please explain any YES answers below:

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## Genitourinary

Do you have or have you had any of the following:

YES NO

|                             |  |  |
|-----------------------------|--|--|
| Any genitourinary disease   |  |  |
| Blood in urine              |  |  |
| Kidney Stones               |  |  |
| Difficulty or painful urine |  |  |

Please explain any YES answers below:

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## Endocrine

Do you have or have you had any of the following:

YES NO

|                                    |  |  |
|------------------------------------|--|--|
| Any endocrine disorder             |  |  |
| Thyroid disease                    |  |  |
| Obesity                            |  |  |
| Unexplained gain or loss of weight |  |  |
| Diabetes Type 1                    |  |  |
| Diabetes Type 2                    |  |  |
| Any hypoglycemic episodes          |  |  |
| Hospitalized for diabetes          |  |  |

Please explain any YES answers below:

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## Dermatology

Do you have or have you had any of the following:

YES NO

|                                          |  |  |
|------------------------------------------|--|--|
| Any skin disease                         |  |  |
| Moles that have changed in size or color |  |  |
| History of skin cancer                   |  |  |

Please explain any YES answers below:

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### Musculoskeletal

Do you have or have you had any of the following:

YES NO

|                                          |  |  |
|------------------------------------------|--|--|
| Any musculoskeletal disease              |  |  |
| Moderate to severe joint pain, arthritis |  |  |
| Amputations                              |  |  |
| Loss of use of arm, leg, fingers or toes |  |  |
| Loss of sensation                        |  |  |
| Loss of strength                         |  |  |
| Loss of coordination                     |  |  |
| Chronic back pain                        |  |  |
| Leg numbness, weakness or pain           |  |  |

Please explain any YES answers below:

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### Neurological

Do you have or have you had any of the following:

YES NO

|                                |  |  |
|--------------------------------|--|--|
| Any neurological disease       |  |  |
| Tremors, shakiness             |  |  |
| Seizures                       |  |  |
| Spinal cord injury             |  |  |
| Numbness or tingling           |  |  |
| Head or spine surgery          |  |  |
| Migraines or chronic headaches |  |  |
| History of brain tumor         |  |  |
| Memory loss                    |  |  |

Please explain any YES answers below:

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### Psychological

Do you have or have you had any of the following:

YES NO

|                                        |  |  |
|----------------------------------------|--|--|
| Any psychological disease              |  |  |
| Insomnia                               |  |  |
| Irritability                           |  |  |
| Loss of interest in doing things       |  |  |
| Anxious or overwhelmed                 |  |  |
| Recurrent bad thoughts                 |  |  |
| Mood swings                            |  |  |
| Hallucinations                         |  |  |
| Compulsions                            |  |  |
| Thoughts of hurting yourself or others |  |  |

Please explain any YES answers below:

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### Your Family History

Do parents or siblings have or had any of the following:

YES NO

|                     |  |  |
|---------------------|--|--|
| Cancer or Leukemia  |  |  |
| Diabetes            |  |  |
| Heart Disease       |  |  |
| High Blood Pressure |  |  |
| Stroke              |  |  |
| Mental illness      |  |  |

Please explain any YES answers below:

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Incomplete forms or missing information may result in a delay clearing you for firefighter duties. Submitting information that is misleading or untruthful may result in termination, criminal sanctions, or failure to be cleared for duty.

This history form and review does not substitute for routine health care or a periodic health examination conducted by your physician. It is being conducted for occupational purposes only. I certify that all of the information I have provided on this form is complete and accurate to the best of my knowledge. I authorize release of information within this form to the Interagency Medical Standards Program Manager or their representative for the purpose of fit for duty clearance as a firefighter.

Candidate's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Examiner: Use space below to comment on positive history on the first six pages:

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Current Primary Care Provider: \_\_\_\_\_

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## Fire Fighter Physical Examination Form

### Vitals:

Vision                      Right eye                      Left eye                      Both Eyes                      Color Vision  
 Distance                      20/\_\_\_\_                      20/\_\_\_\_                      20/\_\_\_\_  
 \_\_\_\_ uncorrected                      \_\_\_\_ corrected  
 Hearing:                      Whisper test \_\_\_\_ R \_\_\_\_ L  
 Height: \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_/\_\_\_\_ O2 Sat: \_\_\_\_\_

### Physical Examination

|                                                                                                                                                                                     |              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|
| Constitutional: Well developed, well nourished, no apparent distress                                                                                                                | Not examined |
| Psychological: Mood and affect appropriate for encounter                                                                                                                            | Not examined |
| Eyes: PERRI, EOMI                                                                                                                                                                   | Not examined |
| ENT: Ear Canals w/o edema or erythema. TM intact w/light reflex                                                                                                                     | Not examined |
| Oropharynx pink with no tonsillar erythema or exudate                                                                                                                               | Not examined |
| No evidence of masses or leukoplakia                                                                                                                                                | Not examined |
| Lymphatic: No cervical adenopathy                                                                                                                                                   | Not examined |
| Skin: No obvious lesions or rashes noted                                                                                                                                            | Not examined |
| Chest/Lungs: CTAB. No rhonchi/wheeze/rate                                                                                                                                           | Not examined |
| Heart/Peripheral Pulses: RRR, no murmurs or peripheral edema                                                                                                                        | Not examined |
| Abdomen: NBS x4 NTTP, no masses or bulges noted                                                                                                                                     | Not examined |
| Neurologic: AAO x 3, patellar reflexes bilaterally                                                                                                                                  | Not examined |
| Musculoskeletal Extremities: 5/5 strength bilateral upper and lower Extremities. Full painless ROM of upper extremities. Quad and hamstring and hip flexor strength 5/5 bilaterally | Not examined |
| Spine: NTTP                                                                                                                                                                         | Not examined |

### Summary of abnormal findings:

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\_\_ Firefighter is FFD

\_\_ Firefighter needs to provide medical information before determination is made

\_\_ Firefighter is NOT FFD

Practitioner Name:

Practitioner Signature \_\_\_\_\_ Date: \_\_\_\_\_

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