Medical History and Examination Form for Firefighters

Clinic Performing Exam	Champlain Medical Urgent Care	**Address**	150 Kennedy Dr, South Burlington, VT 05403
Physician Name	C. Tyler Vogt DO, Beth Schiller ANP, Lianna Percy PA-C, Courtney Randall PA-C, Molly Somaini PA-C	**Phone Number**	(802) 448-9370
		Fax Number	(802) 448-1414

Name of Employing Agency	

Candidate	**Last**		**First**
Position / Job Title			
Date of Birth		**Sex**	❒ Male ❒ Female

* FIREFIGHTERS FILL OUT PAGES 1-6 *

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. Please check your tobacco use status and complete this section.		
❒ **Never Smoked**	**Current Smoker** **❒ Yes ❒ No** Number of cigarettes per day_____ Number of cigars per day_____ Number of pipe bowls per day_____ Amount of chewing tobacco per day_____ Total years of tobacco use_____	**Former Smoker** **❒ Yes ❒ No** Number of cigarettes per day_____ Number of cigars per day_____ Number of pipe bowls per day_____ Amount of chewing tobacco per day_____ 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 _____

Date of last Tetanus Shot: _____ / _____ / ____

(Booster recommended every 10 years)

Firefighter Medical History and Examination Form

Medications	Allergies
List all medications you are currently taking, including those prescribed and over-the-counter (including herbal) as well as the reasons that you are taking them.	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Summary of your medical history

_____
_____
_____
_____
_____
_____

Surgeries

_____
_____
_____
_____
_____
_____

Examiner: Use this space to comment on positive history on this page

MEDICAL HISTORY

Note: For every item checked "Yes" provide dates, treatments, and current status. Use the blank spaces below.

A. Have you ever been treated with an organ transplant, prosthetic device (e.g. artificial hip), or an implanted pump (e.g. for insulin) or electrical device (e.g. cardiac defibrillator)?	❒ Yes ❒ No	
B. Have you had or have you been advised to have an operation?	❒ Yes ❒ No	
C. Have you ever been a patient in any type of hospital?	❒ Yes ❒ No	
D. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past year for other minor illnesses?	❒ Yes ❒ No	
E. Have you been rejected for military service because of physical, mental, or other reasons?	❒ Yes ❒ No	
F. Have you ever been treated for a mental or emotional condition?	❒ Yes ❒ No	
G. Have you ever been diagnosed with or treated for alcoholism or alcohol dependence?	❒ Yes ❒ No	
H. Have you ever been diagnosed as being dependent on illegal drugs, or treated for drug abuse?	❒ Yes ❒ No	
I. Have you ever received, is there pending, or have you applied for a pension or compensation for a disability?	❒ Yes ❒ No	

Vision	**Yes**	**No**
Do you have or have you had any of the following?		
Eye disease	❒	❒
Wear eyeglasses	❒	❒
❒ far ❒ near ❒ both		
Wear contact lenses	❒	❒
❒ hard ❒ soft		
Frequent headaches	❒	❒
Blurred vision	❒	❒
Difficulty reading	❒	❒
Glaucoma	❒	❒
Cataracts	❒	❒
Color blindness	❒	❒

Please explain any YES answers, including dates:

_____

_____

_____

Hearing	**Yes**	**No**
Do you have or have you had any of the following?		
Any ear disease	❒	❒
Loud, constant noise or music in the last 14 hours	❒	❒
Loud, impact noise in the last 14 hours	❒	❒
Ringing in the ears	❒	❒
Difficulty hearing	❒	❒
Ear infections or cold in the last 2 weeks	❒	❒
Dizziness or balance problems	❒	❒
Eardrum perforation	❒	❒
Use of a hearing aid ❒ Left ❒ Right ❒ Both	❒	❒
Use of protective hearing equipment when working around loud noise ❒ foam ❒ pre-mold/plugs ❒ ear muffs		❒

Please explain any YES answers, including dates:

_____

_____

_____

Examiner: Use this space to comment on positive history on this page:

Vascular	**Yes**	**No**
Do you have or have you had any of the following?		
Any vascular disease	❒	❒
Enlarged superficial veins, varicose veins, phlebitis, or blood clots	❒	❒
Anemia	❒	❒
Hardening of the arteries	❒	❒
High Blood Pressure	❒	❒
Stroke or Transient Ischemic Attack (TIA)	❒	❒
Aneurysms	❒	❒
Poor circulation to hands and feet	❒	❒
White fingers with cold / vibration	❒	❒

Please explain any YES answers, including dates:

_____

_____

_____

Heart	**Yes**	**No**
Do you have or have you had any of the following?		
Any heart disease or heart murmurs	❒	❒
Heart or chest pain (angina) with or without exertion	❒	❒
Heart rhythm disturbance or palpitations	❒	❒
History of Heart Attack	❒	❒
Organic heart disease (including prosthetic heart valves, mitral stenosis, heart block, heart murmur, mitral valve prolapse, pacemakers, implanted defibrillator, WPW, etc.	❒	❒
Heart surgery	❒	❒
Sudden loss of consciousness	❒	❒

Please explain any YES answers, including dates:

_____

_____

_____

Respiratory	**Yes**	**No**
Do you have or have you had any of the following?		
Any respiratory disease	❒	❒
Asthma (including exercise induced asthma)	❒	❒
Bronchitis or Emphysema	❒	❒
Excessive, unexplained fatigue	❒	❒
Use of inhalers	❒	❒
Acute or chronic lung infection	❒	❒
Collapsed lung	❒	❒
Scoliosis (curved spine) with breathing limitations	❒	❒
History of Tuberculosis	❒	❒
(Date: ____ / ____ / ____)		

Please explain any YES answers, including dates:

_____

_____

_____

Gastrointestinal	**Yes**	**No**
Do you have or have you had any of the following?		
Any gastrointestinal disease	❒	❒
Hernias	❒	❒
Colostomy	❒	❒
Persistent stomach / abdominal pain / active ulcer	❒	❒
Hepatitis or other liver disease	❒	❒
Irritable bowel syndrome	❒	❒
Rectal bleeding	❒	❒
Vomiting	❒	❒

Please explain any YES answers, including dates:

_____

_____

_____

Examiner: Use this space to comment on positive history on this page:

Genitourinary	**Yes**	**No**
Do you have or have you had any of the following?		
Any genitourinary disease	❒	❒
Blood in urine	❒	❒
Kidney stones	❒	❒
Difficult or painful urination	❒	❒
Infertility (difficulty having children)	❒	❒

Please explain any YES answers, including dates:

_____

_____

_____

Dermatology	**Yes**	**No**
Do you have or have you had any of the following?		
Any skin disease	❒	❒
Sun sensitivity	❒	❒
History of chronic dermatitis	❒	❒
Active skin disease	❒	❒
Moles that have changed in size or color	❒	❒
History of skin cancers	❒	❒

Please explain any YES answers, including dates:

_____

_____

_____

Family History	**Yes**	**No**
Do parents/siblings have any of the following?		
Cancer or Leukemia	❒	❒
Diabetes	❒	❒
Heart Disease	❒	❒
High Blood Pressure	❒	❒
Strokes	❒	❒
Mental Illnesses	❒	❒

Please explain any YES answers, including dates:

_____

_____

_____

Endocrine	**Yes**	**No**
Do you have or have you had any of the following?		
Any endocrine disease	❒	❒
Thyroid disease	❒	❒
Obesity	❒	❒
Unexplained weight loss or gain	❒	❒
Diabetes (Insulin requiring)	❒	❒
If yes, units per day _____. Year diagnoses _____		
Diabetes (Non-insulin requiring)	❒	❒
Year diagnosed _____		
If you have diabetes		
Current medications: _____		
_____		
Last hemoglobin A1c _____% date performed _____		
Have you ever had a hypoglycemic episode	❒	❒
If yes, last date _____		
Have you ever been hospitalized for diabetes	❒	❒
If yes, dates _____, _____, _____		

Please explain any YES answers, including dates:

_____

_____

_____

Are you ❒ right handed ❒ left handed

Examiner: Use this space to comment on positive history on this page:

Musculoskeletal	**Yes**	**No**
Do you have or have you had any of the following?		
Any musculoskeletal disease	❒	❒
Moderate to severe joint pain, arthritis, tendonitis	❒	❒
Amputations	❒	❒
Loss of use of arm, leg, fingers, or toes	❒	❒
Loss of sensation	❒	❒
Loss of strength	❒	❒
Loss of coordination	❒	❒
Chronic back pain	❒	❒
Chronic back pain associated with leg numbness, weakness, or pain	❒	❒
Back surgery within last 2 years	❒	❒

Please explain any YES answers, including dates:

_____

_____

_____

Neurological	**Yes**	**No**
Any neurological disease	❒	❒
Tremors, shakiness	❒	❒
Seizures (current or previous)	❒	❒
Spinal cord injury	❒	❒
Numbness or tingling	❒	❒
Head / Spine surgery	❒	❒
History of head trauma with persistent problems	❒	❒
Chronic or recurring headaches or migraines	❒	❒
History of brain tumor	❒	❒
Loss of memory	❒	❒

Please explain any YES answers, including dates:

_____

_____

_____

Psychological	**Yes**	**No**
Do you have or have you had any of the following?		
Any psychological disease	❒	❒
Insomnia	❒	❒
Irritability	❒	❒
Loss of interest or pleasure in doing things	❒	❒
Feelings of being anxious or overwhelmed	❒	❒
Recurrent bad thoughts	❒	❒
Mood swings	❒	❒
Hallucinations	❒	❒
Compulsions	❒	❒
Thoughts of hurting yourself or others	❒	❒

Please explain any YES answers, including dates:

_____

_____

_____

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 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 (Required):

_____

Date: _____ / _____ /_____

Examiner: Use this space to comment on positive history on this page:

FOR EXAMINERS:

Vital Signs

Height _____ (in.) Weight _____ (lbs)

Resp. _____ / min Temp. _____

Blood Pressure _____ /_____ (sitting)

Pulse _____ / min ❒ Regular ❒ Irregular
If blood pressure is > 180/100 repeat after 10-15 minutes

BMI_____

Head and Neck / ENT Assessment

NL	ABNL	
❒	❒	Head, Face, Neck , Scalp
❒	❒	Eyes / Pupils
❒	❒	Ocular motility
❒	❒	Thyroid
❒	❒	Lymph nodes
❒	❒	Nose / Sinuses
❒	❒	Mouth / Throat
❒	❒	Speech

	Right		Left	
	NL	ABNL	NL	ABNL
Canal/External Ear	❒	❒	❒	❒
Tympanic Membrane	❒	❒	❒	❒

Genitourinary Assessment

NL	ABNL		
❒	❒	External genitalia	❒Not examined

Note: this clearance exam does not require a pelvic exam or PAP smear for females, or a rectal or prostate exam for males

Vision

Able to see red / green / yellow? ❒ Yes ❒ No

Distance:
Right 20 / ____ Left 20 / ____ Both 20 / ____
❒ Corrected ❒ Uncorrected

Peripheral Vision: Right _____° Left _____ °

Cardio/Pulmonary Assessment

NL	ABNL	
❒	❒	Lungs / Chest
❒	❒	Heart (thrill, murmur)
❒	❒	Major blood vessels
❒	❒	Peripheral blood vessels
❒	❒	Resting 12 lead EKG *(Attach with signed interpretation)* ❒ check if not required
❒	❒	Chest X-Ray ❒ check if not required

Gastrointestinal Assessment

NL	ABNL	Yes	No	
❒	❒	Auscultation	❒	❒ Organomegaly
❒	❒	Palpation	❒	❒ Tenderness
			❒	❒ Hernia

Musculoskeletal Assessment

NL	ABNL	
❒	❒	Gait
❒	❒	Upper extremities (Strength)
❒	❒	Upper extremities (Range of motion)
❒	❒	Lower extremities (Strength)
❒	❒	Lower extremities (Range of motion)
❒	❒	Feet
❒	❒	Hands
❒	❒	Spine
❒	❒	Flexibility of neck, back, spine, hips

Examiner: Use this space to comment on positive history on this page:

Dermatology Assessment

NL	ABNL	
❒	❒	Skin

Neurological Assessment

NL	ABNL	
❒	❒	Cranial nerves (II-XII)
❒	❒	Cerebellum
❒	❒	Motor / Sensory (Including vibratory and proprioception
❒	❒	Deep tendon reflexes

Psychological Assessment

NL	ABNL	
❒	❒	Mood
❒	❒	Affect
❒	❒	Behavior
❒	❒	Speech
❒	❒	Mental Status

Coronary Risk Factors	Yes	No
Blood Pressure > $^{140}/_{90}$ or on HTN med	❒	❒
Diabetes or Fasting Glucose > 126 mg/dl	❒	❒
Total Cholesterol > 200 mg/dl or HDL < 40 mg/dl	❒	❒
Family history of CVD in males <55	❒	❒
Age (men >/= 45, women >/= 55)	❒	❒
No regular exercise program	❒	❒
Current smoker	❒	❒

Examiner: Use this space to comment on positive history on this page or on the examination in general:

Examining Provider Signature	**Examining Provider Printed Name**	**Date** ____ / ____ / ____	
Examiner's Address	Champlain Medical Urgent Care 150 Kennedy Dr. South Burlington, VT 05403	**Phone Number**	(802)448-9370

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