Corporate Health Fire Fighter
Annual Patient Health Review

Today's Date: ____/____/____

Personal Information:

Legal Name: _____
(Last) (First) (M.I.)
AKA or Nickname: _____
SSN: _____-____-_____ Date of Birth: ____/____/____ Sex: M / F
Marital Status: _____
Address: _____
City: _____ State: _____Zip: _____
Work Phone: _____ Home /Cell Phone: _____
Best Time To Contact You: _____ AM/PM

Employer Information:

Name of Home Department: _____
Specify: _____ Hire Date: ____/____/____
Employer Phone: _____
Rank/Title: _____
District: _____ Shift: _____ Station: _____Unit: _____(ie E, L, R)
Retirement Date: ____/____/____

Emergency Notification Information:

In case of emergency, notify: _____
Relationship: _____ Phone: _____
Address: _____
City: _____ State: _____Zip: _____

Personal Family Physician Information:

Personal Physician: _____ Phone: _____
Address: _____
City: _____ State: _____Zip: _____

Education Years: (Check highest level)

☐ High School ☐ AA ☐ BA/BS ☐ MA/MS ☐ Other (Specify): _____

Past Medical Problems/Hospitalizations:

Since your last exam, have you been hospitalized? ☐ Yes ☐ No
If yes, please provide details:
Date(s): _____ Reason: _____
_____
Since your last exam, have you had surgery(s)? ☐ Yes ☐ No
If yes, please provide dates and reasons for surgery:
Date(s): _____ Reason: _____
_____

Since your last exam, have you had problems with any of the following? Check all appropriate

Yes	*No*		*Year*	*Yes*	*No*		*Year*	*Yes*	*No*		*Year*
☐	☐	Abdominal pain		☐	☐	Edema/swelling		☐	☐	Paralysis	
☐	☐	Abnormal bleeding		☐	☐	Epilepsy/Seizures		☐	☐	Personality Change	
☐	☐	Allergies		☐	☐	Emphysema		☐	☐	Pneumonia	
☐	☐	Anemia		☐	☐	Fainting Spells		☐	☐	Pneumothorax/ Collapsed Lung	
☐	☐	Arm or Leg Pain		☐	☐	Fever		☐	☐	Prostate Symptoms	
☐	☐	Arthritis		☐	☐	Fractures (Broken Bones)		☐	☐	Sexual Problems	
☐	☐	Asthma		☐	☐	Gall Bladder/Stones		☐	☐	Sickle Cell Disease/Trait	
☐	☐	Back Pain or Trouble		☐	☐	Hair loss		☐	☐	Sinus Trouble	
☐	☐	Blood Loss		☐	☐	Headache		☐	☐	Skin Problem	
☐	☐	Blood Pressure		☐	☐	Heat injury		☐	☐	Stress Problems	
☐	☐	Bone/ Joint Deformity		☐	☐	Hemorrhoids/Piles		☐	☐	Testicular Pain/Problems	
☐	☐	Bowel Problems		☐	☐	Hepatitis or Liver Trouble		☐	☐	Thyroid Disease	
☐	☐	Breast – Mass/Pain/Problems		☐	☐	Hernia		☐	☐	Tremor/shake	
☐	☐	Bronchitis		☐	☐	Indigestion		☐	☐	Trouble smelling odors	
☐	☐	Cancer		☐	☐	Insomnia		☐	☐	Tuberculosis	
☐	☐	Chest Pain		☐	☐	Joint Pain/problem		☐	☐	Positive TB skin test	
☐	☐	Chicken Pox		☐	☐	Kidney stones		☐	☐	Tumors or cysts	
☐	☐	Chronic Cough		☐	☐	Leg cramps		☐	☐	Ulcers	
☐	☐	Claustrophobia		☐	☐	Lung or Breathing problems		☐	☐	Unexpected Weight Change	
☐	☐	Cold or Painful Fingers		☐	☐	Memory Loss		☐	☐	Urinary Trouble	
☐	☐	Tooth or Gum Problems		☐	☐	Migraine		☐	☐	Varicose Veins	
☐	☐	Depression or Excessive Worry		☐	☐	Muscle Ache/Pain		☐	☐	Venereal Disease	
☐	☐	Dizziness		☐	☐	Nervousness		☐	☐	Weakness	

Please explain any positive responses from above: _____
_____
_____
_____
_____

Yes No

☐ ☐ Have you ever had an eye exam by a specialist? When was your last exam? _____

☐ ☐ Have you ever been told that you had glaucoma?

☐ Have you ever lost vision in either eye (temporarily or permanently)?

Reviewed with patient by: _____ Date: _____

Yes *No*

☐ ☐ Have you used any inhaled medications (aerosolized inhaler) in the past hour?

☐ ☐ Have you eaten a heavy meal in the past hour?

☐ ☐ Have you had any respiratory infection (cold, flu, pneumonia, bronchitis) in the past 3 weeks?

If yes, please explain: _____

☐ ☐ Have you taken any antihistamines (Benadryl, Claritin, etc) within the past 3 days?

If yes, please list name and time of last dose: _____

☐ ☐ Is there a possibility that you may be pregnant?

1. Today's date: _____
2. Your age (to nearest year): _____
3. Sex: ☐ Male ☐ Female
4. Your height: _____ ft. _____in.
5. Your weight: _____lbs.
6. Your job title: _____
7. A phone number where you can be reached by the health care professional who reviews this questionnaire: ( ) _____
8. The best time to phone you at this number: _____
9. Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No
10. Check the type of respirator you will use (you can check more than one category):

    ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only)

    ☐ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

12. Have you worn a respirator: ☐ Yes ☐ No If yes, what type(s): _____

Yes ***No***

1. ☐ ☐ Do you currently smoke tobacco, or have you smoked tobacco in the last month?
2. Have you **ever had** any of the following conditions?

Yes ***No***

a. ☐ ☐ Seizures (fits)
b. ☐ ☐ Diabetes (sugar disease)
c. ☐ ☐ Allergic reactions that interfere with your breathing
d. ☐ ☐ Claustrophobia (fear of closed-in places
e. ☐ ☐ Trouble smelling odors

3. Have you **ever had** any of the following pulmonary or lung problems?

Yes ***No***

a. ☐ ☐ Asbestosis
b. ☐ ☐ Asthma
c. ☐ ☐ Chronic bronchitis
d. ☐ ☐ Emphysema
e. ☐ ☐ Pneumonia
f. ☐ ☐ Tuberculosis
g. ☐ ☐ Silicosis

*h.	☐	☐	Pneumothorax (collapsed lung)
i.	☐	☐	Lung cancer
*j.	☐	☐	Broken ribs
*k.	☐	☐	Any chest injuries or surgeries
l.	☐	☐	Any other lung problem that you've been told about

4. Do you **currently have** any of the following symptoms of pulmonary or lung illness?

	Yes	***No***	
a.	☐	☐	Shortness of breath
b.	☐	☐	Shortness of breath when walking fast on level ground or walking up a slight hill or incline
c.	☐	☐	Shortness of breath when walking with other people at an ordinary pace on level ground
d.	☐	☐	Have to stop for breath when walking at your own pace on level ground
e.	☐	☐	Shortness of breath when washing or dressing yourself
f.	☐	☐	Shortness of breath that interferes with your job
g.	☐	☐	Coughing that produces phlegm (thick sputum)
h.	☐	☐	Coughing that wakes you early in the morning
i.	☐	☐	Coughing that occurs mostly when you are lying down
*j.	☐	☐	Coughing up blood in the last month
k.	☐	☐	Wheezing
l.	☐	☐	Wheezing that interferes with your job
m.	☐	☐	Chest pain when you breathe deeply
n.	☐	☐	Any other symptoms that you think may be related to lung problems

5. Have you **ever had** any of the following cardiovascular or heart problems?

	Yes	***No***	
*a.	☐	☐	Heart attack
b.	☐	☐	Stroke
*c.	☐	☐	Angina
d.	☐	☐	Heart failure
e.	☐	☐	Swelling in your legs or feet (not caused by walking)
f.	☐	☐	Heart arrhythmia (heart beating irregularly)
*g.	☐	☐	High blood pressure
h.	☐	☐	Any other heart problem that you have been told about

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

	Yes	***No***	
*a.	☐	☐	Frequent pain or tightness in your chest
b.	☐	☐	Pain or tightness in your chest during physical activity
c.	☐	☐	Pain or tightness in your chest that interferes with your job
d.	☐	☐	In the past two years, have you noticed your heart skipping or missing a beat
e.	☐	☐	Heartburn or indigestion that is not related to eating
f.	☐	☐	Any other symptoms that you think may be related to heart or circulation problems

7. Do you **currently take** medication for any of the following problems?

	Yes	***No***	
a.	☐	☐	Breathing or lung problems
b.	☐	☐	Heart trouble
c.	☐	☐	Blood pressure
d.	☐	☐	Seizures (fits)

8. If you have used a respirator, have you ever had any of the following problems? If you have never used a respirator, check the following space and go to next question: ☐ Never used a respirator

	Yes	***No***	
a.	☐	☐	Eye irritation
b.	☐	☐	Skin allergies or rashes
c.	☐	☐	Anxiety

d. ☐ ☐ General weakness or fatigue
e. ☐ ☐ Any other problem that interferes with your use of a respirator

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

	Yes	***No***	
a.	☐	☐	

The questions below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

	Yes	***No***	
10.	☐	☐	Have you ever lost vision in either eye (temporarily or permanently)?
11.			Do you currently have any of the following vision problems?
	Yes	***No***	
a.	☐	☐	Wear contact lenses
b.	☐	☐	Wear glasses
c.	☐	☐	Color blind
*d.	☐	☐	Any other eye or vision problem
12.	☐	☐	Have you ever had an injury to your ears, including a broken ear drum
13.			Do you **currently have** any of the following hearing problems?
	Yes	***No***	
a.	☐	☐	Difficulty hearing
b.	☐	☐	Wear a hearing aid
*c.	☐	☐	Draining or painful ear
*d.	☐	☐	Ear infection
e.	☐	☐	Any other hearing or ear problem
14.	☐	☐	Have you ever had a back injury
15.			Do you **currently have** any of the following musculoskeletal problems?
	Yes	***No***	
a.	☐	☐	Weakness in any of your arms, hands, legs, or feet
b.	☐	☐	Back pain
c.	☐	☐	Difficulty fully moving your arms and legs
d.	☐	☐	Pain or stiffness when you lean forward or backward at the waist
e.	☐	☐	Difficulty fully moving your head up or down
f.	☐	☐	Difficulty fully moving your head side to side
g.	☐	☐	Difficulty bending at your knees
h.	☐	☐	Difficulty squatting to the ground
i.	☐	☐	Climbing a flight of stairs or a ladder carrying more than 25 lbs.
j.	☐	☐	Any other muscle or skeletal problem that interferes with using a respirator

Since your last exam, have you developed any new medical problems (not listed above)?
☐ Yes☐ No If yes, provide details: Date(s): _____ Description: _____
_____

Habits:

Yes *No*

☐ ☐ Do you drink alcoholic beverages? If yes, answer the following: (One drink + 1 bottle of beer, 1 glass of wine, or 1 drink of liquor.

How many drinks do you drink each week? _____

☐ ☐ If no, are you a former smoker or tobacco user ?

If yes, how long ago did you quit?_____ How long did you use tobacco before you quit?_____

How many do you smoke/chew? Cigarettes/d ____ Cigars/d _____ Cans/w_____ Pipes/d ____

☐ ☐ How much caffeine do you drink per day (coffee, tea, energy drinks). Which kind?_____

Fitness Review:

Please list your exercise activities and number of times per week you perform each.

Aerobic _____ X per week in the past month
Walking _____ X per week in the past month
Weight Training _____ X per week in the past month
Other: _____
_____

Since your last exam, compare your activity level: ☐ More ☐ Less ☐ Same

Cumulative EMS/Fire Experience:

Indicate the # of years in each position(s):
Firefighter _____ Engineer _____ Captain _____ BC _____ Admin _____

Select the type of respirator(s) you used: ☐ SCBA ☐ MP5 ☐ Other _____

Occupational Exposures:

Have you had any work related exposures to fires of HAZMAT situations where you have developed health changes or have concerns about your health? ☐ Yes ☐ No

If yes, provide details: _____
_____
_____

Yes *No*

☐ ☐ Have you developed any allergies?

☐ Pollen ☐ House Dust ☐ Drugs ☐ Vaccines ☐ Serum ☐ Food

☐ Animal dander, feathers, or fur ☐ Metal, jewelry ☐ Sunlight or cold

☐ Other allergies _____

☐ ☐ Do you have any second jobs or side businesses? If yes, what is it? _____
_____

☐ ☐ Do you have a prior occupation? If yes, please list. _____

☐ ☐ Have you been in the military services:

☐ ☐ If yes, were you exposed to biologic or chemical agents (in either training or combat)

If yes, please identify the agent._____

☐ ☐ Have you ever worked on a HAZMAT Team?

☐ ☐ Do you use firearms for hunting, or recreation?

☐ ☐ Do you have exposure to racing cars, ATVs. Motocycles, or other loud vehicles?

☐ ☐ Do you use power tools?

☐ ☐ Do you listen to loud music or bands?

☐ ☐ When you are exposed to noise do you wear hearing protection? What kind? _____

☐ ☐ Do you use any chemicals/ materials in your hobbies(eg solvents, solder, pesticides, lead or other metals,

If yes, provide details _____

Additional Information

Yes	*No*		*Yes*	*No*	
☐	☐	Noisy Second Job	☐	☐	Noisy Past Job
☐	☐	Recent Change in Hearing	☐	☐	Current Ear Problem

Medication Review:

List any drugs (by name) you have taken regularly and the dosage used. Include all prescription and non-prescription (over the counter medicines) that you take including all supplements.

_____

_____

_____

Have you had any difficulties having children (e.g. Infertility, Miscarriage, Spontaneous Abortion)? ☐ Yes ☐ No

If yes, provide details below: _____

_____

_____

Advance Directives

Yes *No*

☐ ☐ Do you have Advance Directives? Advance Directives presented at subsequent visits will be entered into your medical record and will be followed.

Employee Name - Printed	Employee Signature	Date
Nurse Reviewing Medical Evaluation Name - Printed	Nurse Reviewing Medical Evaluation Signature	Date