Firefighter Medical Examination Form

Name: ____
Sin #: ______________________________
Date of Exam : ______________________________

Type of Exam □ Replacement □Periodic □Other ______________________________

SMOKING HISTORY	□ Current Smoker # cigarettes/day _____ total yrs. smoked _____ □ Former Smoker # cigarettes/day _____ total yrs. smoked _____ □ Never Smoked
ALCOHOL HISTORY	What is your average alcohol consumption (#drinks/week)? __________ drinks If you drink, what is your usual pattern of drinking? □ Weekdays □ Weekends □ Both
DRUG HISTORY	Do you use recreational drugs? □ No □ Yes Describe _________________________
EXERCISE HISTORY	Type of exercise or activity you do ____ Intensity? □ Low (walking) □ Moderate (jogging/cycling) □ High (sustained heart rate) Duration of exercise in minutes/session - _____________ days/week - _____________
MEDICATIONS	List all current medications ____
IMMUNIZATIONS	Date of last tetanus shot __________________________ Received Hepatitis B Vaccine? □ No □ Yes completed series □ Series not completed If vaccinated against Hepatitis B did you get a titer? □ No □ Yes – Result ____________
GENERAL MEDICAL HISTORY	□ Y □ N 1. Have you ever been treated with an organ transplant, prosthetic device or an implanted pump or electrical device? □ Y □ N 2. Have you had or have you been advised to have any operations? □ Y □ N 3. Have you ever been a patient in any type of hospital after childhood? □ Y □ N 4. Have you consulted or been treated by health care workers within the past year for other than minor illnesses? □ Y □ N 5. Have you ever been rejected or discharged from military service due to physical, mental or other reasons? □ Y □ N 6. Have you ever had or been treated for a mental or emotional condition? □ Y □ N 7. Have you ever received, is there pending, or have you applied for a pension or compensation for a disability? □ Y □ N 8. Do you have any allergies, such as to Poison Oak, latex, pollen, or dust? Explain above Yes answers: ____

PATIENT QUESTIONS		
HEAD/EYES		
Y	N	Any eye disease?
Y	N	Wear glasses or contacts?
Y	N	Have frequent headaches?
Y	N	Blurred vision?
Y	N	Cataracts?
Y	N	Thyroid disease?
EARS		
Y	N	Any ear disease?
Y	N	Difficulty hearing?
Y	N	Dizziness/balance problems?
Y	N	Use a hearing aid?
SKIN		
Y	N	Any skin disease?
Y	N	History of chronic dermatitis?
Y	N	Problems with easy bruising?
VASCULAR		
Y	N	Any vascular disease?
Y	N	Phlebitis or blood clots?
Y	N	Anemia?
Y	N	High blood pressure?
Y	N	Stroke or TIA?
Y	N	Aneurysms (dilated arteries)?
Y	N	Poor circulation hands/feet?
CARDIAC		
Y	N	Any heart disease/murmurs?
Y	N	Chest pain with exertion/rest?
Y	N	Rhythm problems/palpitations?
Y	N	History of heart attack?
Y	N	Heart surgery?
RESPIRATORY		
Y	N	Any respiratory disease?
Y	N	Asthma/bronchitis/emphysema?
Y	N	Use of inhalers?
Y	N	Short of breath with exertion?
Y	N	Acute/chronic lung infection?
Y	N	History of tuberculosis?
Y	N	History of (+) TB skin test?

MUSCULOSKELETAL		
Y	N	Any musculoskeletal disease?
Y	N	Moderate to severe joint pain?
Y	N	Arthritis or tendinitis?
Y	N	Amputations?
Y	N	Loss use of arm/leg/fingers/toes?
Y	N	Loss of sensation?
Y	N	Loss of strength?
Y	N	Loss of coordination?
Y	N	Chronic back pain?
NEUROLOGIC		
Y	N	Any neurological disease?
Y	N	Seizures (current or previous)?
Y	N	Numbness or tingling?
Y	N	History of head trauma?
Y	N	Chronic recurring headaches?
Y	N	Dizziness or fainting spells?
GI		
Y	N	Any gastrointestinal disease?
Y	N	Diabetes/high blood sugar?
Y	N	Hiatal hernia/active ulcer?
Y	N	Stomach/abdominal pains?
Y	N	Irritable bowel syndrome?
Y	N	Rectal bleeding?
Y	N	Vomiting blood?
GU		
Y	N	Blood in urine?
Y	N	Kidney stones?
Y	N	Difficult or painful urination?
Y	N	Hernia?
Y	N	(Men) Prostate/testicular problem?
Y	N	(Men) Breast tender/swollen/lumps?
Y	N	(Women) Menstrual irregularities?
Y	N	(Women) Breast mass/lumps?
Y	N	(Women) Are you pregnant?

PHYSICAN EXAMINATION		
HEAD/EYES		
WNL	Abnl	Head /face/neck/scalp
WNL	Abnl	Nose/sinuses/Eustachian tube
WNL	Abnl	Mouth/throat
WNL	Abnl	Pupils equal/reactive
WNL	Abnl	Ocular motility
WNL	Abnl	Ophthalmoscopic findings
Y	N	Far VA uncorrected at least 20/100
Y	N	Far VA corrected at least 20/40
Y	N	Color Normal-red/green/amber
Y	N	Peripheral vision at least 85°
Y	N	Depth perception at least 6/9
EARS		
WNL	Abnl	TMs
WNL	Abnl	Canals
WNL	Abnl	Pinnas
Y	N	Audiogram (500,1K,2K,3K<40dB)
SKIN		
WNL	Abnl	Skin
VASCULAR		
WNL	Abnl	Major blood vessels
WNL	Abnl	Femoral pulses
WNL	Abnl	Peripheral blood vessels
WNL	Abnl	CXR
Y	N	BP< 140/90
CARDIAC		
WNL	Abnl	Heart
WNL	Abnl	EKG
RESPIRATORY		
WNL	Abnl	Lungs/chest
Y	N	PFT(FVC at least 70% predicted)
Y	N	PFT (FEV_1/FVC at least 70% predicted)
MUSCULOSKELETAL		
WNL	Abnl	Upper extremities (strength)
WNL	Abnl	Upper extremities (ROM)
WNL	Abnl	Lower extremities (strength)
WNL	Abnl	Lower extremities (ROM)
WNL	Abnl	Feet
WNL	Abnl	Hands
WNL	Abnl	Grip strength
WNL	Abnl	Spine
WNL	Abnl	Flexibility neck/back/spine/hips
NEUROLOGIC		
WNL	Abnl	Cranial nerves (I-XII)
WNL	Abnl	Cerebellum
WNL	Abnl	Motor/Sensory
WNL	Abnl	Deep Tendon Reflexes
WNL	Abnl	Mental status exam
GI		
WNL	Abnl	Auscultation
WNL	Abnl	Palpation
Y	N	Organo-megaly
Y	N	Tenderness
GU		
WNL	Abnl	Genitals
WNL	Abnl	Prostate
WNL	Abnl	Rectal
Y	N	Hernia

Comments: ________________________________

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Examining Provider's Summary

□ A. **NO SIGNIFICANT FINDINGS.** The individual appears to meet the medical standards. There is no apparent reason why the examinee cannot perform the functional requirements of a firefighter.

□ B. **SIGNIFICANT FINDING (uncorrected Far Vision)**. The individual does not meet the uncorrected far vision standard. An acceptable accommodation may be to require the possession during duty hours of a second set of corrective lenses. With this accommodation, there is no apparent reason why the examinee cannot perform the functional requirements of a firefighter.

□ C. **SIGNIFICANT MEDICAL FINDINGS**. The individual does not appear to meet one or more of the medical standards, or is not considered able to safely participate in arduous duty performance testing.

□ D**. FINAL DETERMINATIN CANOT BE MAKE BASED ON AVAILABLE MEDICAL INFORMATION.** The results were inclusive and require that further information be provided to the examiner form the examinee's personal health care provider. Final recommendations cannot be made until this has been accomplished.

______________________________ ______________

(Examining Provider's Signature) (Date)

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(Patient's Signature)