

**COLUMBIA MEMORIAL HOSPITAL
FIREFIGHTER PHYSICAL EVALUATION FORM**

PLEASE COMPLETE THE FOLLOWING INFORMATION

FIRE COMPANY: _____

NAME: _____ DATE: _____

SOCIAL SECURITY NUMBER: ____ / ____ / ____ DATE OF BIRTH: _____

HOME ADDRESS: _____

HOME PHONE: _____

PRIMARY PHYSICIAN: _____ Physician phone: _____

PRIMARY PHYSICIAN ADDRESS: _____

Which category below best describes your current category of firefighting activity? Circle one category.

| | | | |
|---|---|---|--|
| <p><u>Category A</u> Interior Firefighting</p> | <p><u>Category B</u> Exterior Firefighting (Emergency Use of SCBA)</p> | <p><u>Category C</u> Exterior Support Activities (No Respirator Use) Driver/Operator</p> | <p><u>Category D</u> Administrative Activities Fire Police Duties</p> |
|---|---|---|--|

If you are medically qualified, would you wish to be upgraded to a higher firefighter category?

Please circle "YES" or "NO"

Please turn to the next page to complete your medical history.

Do not write in this box – For Medical Providers only

Clearance Category: A B C D

Firefighter Complete Exam

Firefighter Brief Exam

- | | | | |
|---|--------------------------------|----------------------------------|------------------------|
| <input type="checkbox"/> PFT done | Normal | Abnormal | |
| <input type="checkbox"/> EKG done | Normal | Abnormal | N/A |
| <input type="checkbox"/> Audiogram done | Normal | Abnormal | N/A |
| <input type="checkbox"/> Lab Studies done | Normal | Abnormal | (for Hazmat team only) |
| <input type="checkbox"/> Urine dip done | Normal | Abnormal | |
| <input type="checkbox"/> Fingertick Glucose | Normal | Abnormal | |
| <input type="checkbox"/> Hep B titer done | | | |
| <input type="checkbox"/> Vaccine done | <input type="checkbox"/> Hep B | <input type="checkbox"/> Tetanus | |

Comments: _____

YES NO Appropriate for firefighting level requested by the firefighter?
If "NO", please explain reason on the back-side of this sheet.

Where was physical performed? Occ. Health office / Firehouse / Clinic (name) _____

Provider Signature: _____ Date: _____

Print Name: _____

PULMONARY

PHYSICAL QUESTIONNAIRE

Have you ever had any of the following pulmonary or lung illnesses?

YES NO Asbestosis

YES NO Asthma

YES NO Broken ribs

YES NO Chronic bronchitis

YES NO Emphysema

YES NO Lung cancer

YES NO Pneumonia

YES NO Pneumothorax (collapsed lung)

YES NO Silicosis

YES NO Tuberculosis

YES NO Have you ever had any lung or chest surgeries or injuries?

If "YES", please explain: _____

YES NO Have you ever had a chest x-ray? Please give the approximate date of your most recent:

Date: _____ Was it NORMAL? ABNORMAL? NOT SURE? (please circle one)

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

YES NO Shortness of breath

YES NO Shortness of breath when walking fast on level ground or walking up a slight hill or incline

YES NO Shortness of breath when walking with other people at an ordinary pace on level ground

YES NO Have to stop for breath when walking at your pace on level ground

YES NO Shortness of breath when washing or dressing yourself

YES NO Shortness of breath that interferes with your job

YES NO Coughing that produces phlegm (thick sputum)

YES NO Coughing that wakes you early in the morning

YES NO Coughing that occurs mostly when you are lying down

YES NO Coughing up blood in the last month

YES NO Wheezing

YES NO Wheezing that interferes with your job

YES NO Chest pain when you breathe deeply

YES NO Allergic reactions that interfere with your breathing

YES NO Do you have any other lung problems that you have been told about?

If "YES", please explain: _____

YES NO Has your doctor recommended that you **currently** limit any of your work, recreation or hobby activities due to any of the lung problems listed above?

If "YES", please explain: _____

CARDIOVASCULAR

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

- YES NO Angina
- YES NO Coronary artery bypass surgery or an angioplasty/balloon catheterization YEAR _____
- YES NO Heart arrhythmia (irregular heart beat)
- YES NO Heart attack (MI)
- YES NO Heart failure
- YES NO Heart murmur
- YES NO High blood pressure
- YES NO Swelling in your legs or feet (not caused by walking)

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

- YES NO Frequent pain or tightness in your chest at rest
- YES NO Pain or tightness in your chest during physical activity
- YES NO In the past two years, have you noticed your heart skipping or missing a beat
- YES NO Heartburn or indigestion that is related to physical activity
- YES NO Any other symptoms that you think may be related to heart or circulation problems:
Please explain: _____
- YES NO Have you ever had an EKG (electrocardiogram)? Please give the approximate date of your most recent EKG: _____
Was it NORMAL ~ ABNORMAL ~ DON'T KNOW? (Please circle one)
- YES NO Have you ever had a Stress Test or treadmill EKG (electrocardiogram)? Please give the approximate date of your most recent stress test: _____
Was it NORMAL ~ ABNORMAL ~ DON'T KNOW? (Please circle one)
- YES NO Has your doctor recommended that you **currently** limit any of your work, recreation or hobby activities due to any of the heart problems listed above?
If "YES", please explain: _____

NEUROLOGIC

Have you ever had any of the following neurologic conditions?

YES NO Frequent headaches

YES NO Multiple sclerosis

YES NO Paralysis/Spinal cord injury

YES NO Seizures/Epilepsy (fits)

YES NO Stroke/Cerebral Vascular Accident

YES NO Any other neurological illness or injury? Please explain: _____

YES NO Has your doctor recommended that you **currently** limit any of your work, recreation or hobby activities due to any of the neurological problems?

If "YES", please explain: _____

GASTROINTESTINAL/KIDNEY

Have you ever had any of the following INTESTINAL/STOMACH/KIDNEY conditions?

YES NO Appendicitis

YES NO Gallbladder

YES NO Hiatal hernia

YES NO Liver Disease (Cirrhosis, Hepatitis)

YES NO Reflux (GERD)

YES NO Ulcers

YES NO Any other intestinal or kidney illness or injury? Please explain: _____

YES NO Has your doctor recommended that you **currently** limit any of your work, recreation or hobby activities due to any of the intestinal or kidney problems listed?

If "YES", please explain: _____

EYES

Do you currently have any of the following vision problems?

YES NO Cataracts

YES NO Color blind

YES NO Glaucoma

YES NO Lost vision in either eye (temporarily or permanently)?

YES NO Wear contact lenses or wear glasses

YES NO Any other eye or vision problem? Please explain: _____

EARS

Do you currently have any of the following hearing problems?

YES NO Broken ear drum

YES NO Difficulty hearing _____ Left ear AND/OR _____ Right ear

YES NO Ringing in the ears

YES NO Wear a hearing aid

YES NO Any other hearing or ear problems? Please explain: _____

MUSCULOSKELETAL

Do you currently have any of the following musculoskeletal problems?

YES NO Arthritis

YES NO Back pain, including sciatica, herniated or bulging disk, arthritis, or muscle strain

YES NO Difficulty climbing a flight of stairs or ladder carrying more than 25 pounds

YES NO Difficulty or weakness fully moving your arms and legs

YES NO Difficulty fully moving your head in any direction

YES NO Difficulty bending at your knees.

YES NO Difficulty squatting to the ground

YES NO Gout

YES NO Pain or stiffness when you lean forward or backward at the waist

YES NO Any other muscle or skeletal problem that interferes with performing work activities including using a respirator? Please explain: _____

YES NO Has your doctor recommended that you **currently** limit any of your work, recreation or hobby activities due to any of the musculoskeletal problems listed?

If "YES", please explain: _____

GENERAL MEDICAL

Do you have any of the following:

- YES NO Anemia
YES NO Cancer
YES NO Claustrophobia (fear of closed-in places)
YES NO Diabetes (sugar disease)
YES NO Thyroid disease
YES NO Trouble smelling odors

TOBACCO & ALCOHOL

YES NO Do you currently smoke tobacco?

YES NO Have you in the past smoked tobacco?

If you have smoked or do smoke, how many years have you smoked? _____

How many packs per day have/do you smoke? _____

YES NO Do you drink alcohol?

On the average, how much of the following do you drink per week?

Beer: _____ cans/bottles Wine: _____ glasses Whiskey/liquor: _____ jiggers/shots

FAMILY MEDICAL HISTORY

If a family member has had any of the following medical conditions, please write the number which corresponds to that family member in the space provided.

| | | | | |
|--------------------|-------------------------------|--------------------|------------------------|-------------|
| 1. Father | 2. Mother | 3. Grandparent | 4. Brother/Sister | 5. Children |
| _____ Cancer | _____ Liver disease/Cirrhosis | _____ Diabetes | _____ Seizure/Epilepsy | |
| _____ Hypertension | _____ Heart disease | _____ Lung disease | | |

YES NO Is your father still living? If "NO", what age did he die? _____

What was his cause of death? _____

YES NO Is your mother still living? If "NO", what age did she die? _____

What was her cause of death? _____

RESPIRATORY PROTECTION

Check the type of respirator you will use (you can check more than one category)

- a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only)
- b. _____ Other type (for example: half-or full-face piece type, powered-air purifying, supplied-air, **self contained breathing apparatus**)

YES NO Have you worn a respirator? If "YES", please circle what type(s):

Disposable/paper mask

Filter/cartridge style or half or full face piece mask

Military gas mask

Self Contained Breathing Apparatus (SCBA)

Supplied-Air or Type C respirator

If you have **used a respirator**, have you ever had any of the following problems related to using a respirator?

YES NO Anxiety

YES NO Eye irritation/Difficulty seeing in your mask

YES NO Shortness of breath

YES NO Skin allergies or rashes

YES NO Any other problem that interferes with your use of a respirator?

Please explain: _____

PROTECTIVE EQUIPMENT

YES NO Do you have a latex or rubber sensitivity?

YES NO Do you get rashes after wearing protective clothes?

YES NO Do you become overheated wearing protective clothes?

HEALTH STATUS

Please indicate what you believe your health status is today: ___Excellent ___Good ___Fair ___Poor

YES NO Have you been examined or treated by a health care provider within the last 12 months for?

Injury (please explain) _____

Illness (please explain) _____

Routine physical or follow-up (please explain) _____

SURGICAL HISTORY

Please list any surgical procedures you have had, and if possible, list dates (or approximate) dates:

| | |
|--------------------|-------|
| _____ | _____ |
| surgical procedure | date |
| _____ | _____ |
| surgical procedure | date |
| _____ | _____ |
| surgical procedure | date |
| _____ | _____ |
| surgical procedure | date |
| _____ | _____ |
| surgical procedure | date |
| _____ | _____ |
| surgical procedure | date |

MEDICATION LIST

Please list any medications that you are currently taking:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____

I have answered this health questionnaire completely and honestly and understand I can review any questions with my examiner if I am unsure or need to further explain.

Employee Signature: _____ Date: _____

AUDIOMETRIC EVALUATION

Name: _____ SSN: _____

Employer _____ Periodic []

DOB _____ Age _____ Date _____ Pre-employment []

Occupation: _____ Re-test []

PLEASE CIRCLE ANSWERS TO QUESTIONS 1 – 11:

- 1. Have you had any loud noise exposure in the past 14 hours (prior to test)? YES NO
- 2. Are you experiencing a ringing, buzzing, or plugging sensation in either ear today? YES NO
- 3. Do you ever have ringing in your ears? YES NO
- 4. Do you have a "head cold" or congestion today? YES NO
- 5. Have you ever been exposed to loud noise from military activities? YES NO

If "YES", please explain the type of noise: _____

Length of time (years) of exposure _____ years

- 6. Have you ever worked on a noisy job? YES NO

If "YES", please explain: _____

Length of time (years) of exposure _____ years

- 7. Have you had regular exposure to any of the following non-occupational noise sources? :

Power or Air Tools _____ Target shooting or hunting _____ Chain Saws _____

Motorcycles/snowmobiles _____ Loud music _____ Other: _____

- 8. Have you ever been found to have a hearing loss? YES NO

If "YES", please explain: _____

- 9. Does anyone in your family have a hearing loss? YES NO

- 10. Do you wear a hearing aid? YES NO

- 11. Have you ever had any of the following:

| | | | | | |
|----------------|-----|----|-----------------------------|-----|----|
| Ear infections | YES | NO | Diabetes | YES | NO |
| Ear injury | YES | NO | Head injury | YES | NO |
| Ear surgery | YES | NO | Mumps/Measles/Scarlet Fever | YES | NO |
| Stroke | YES | NO | | | |

Employee Signature: _____ Date: _____

NAME: _____ DATE: _____

Employer: _____ DOB: _____

Date of Exam: _____

Blood Pressure ____/____ Pulse ____ (regular/irregular)

Height ____ (in) Weight ____ (lbs)

Fingerstick Glucose: Normal / Abnormal

Urine dip: Normal / Abnormal (presence of glucose, protein and/or blood)

| |
|-------------------|
| PFT: |
| Reading #1 _____ |
| Reading #2 _____ |
| Reading #3 _____ |
| Avg: _____ |

VISION Corrective lenses? Yes or No

| VISION | OD (Right) | OS (Left) | OU (Both) |
|------------|-------------------|-------------------|-----------|
| DISTANCE | 20 / | 20 / | 20 / |
| NEAR | 20 / | 20 / | 20 / |
| COLOR | Normal / Abnormal | Normal / Abnormal | |
| PERIPHERAL | | | |

HEARING Perceives whisper at five (5) feet? AS Yes or No AD Yes or No

PHYSICAL EXAM

| | Normal | Abnormal | Comments |
|---------------------|--------|----------|--|
| 1. Eyes | | | Abnormal discs or fundi? Unequal pupils? Cataracts? |
| 2. Ears | | | TM scarring? TM perforation? Excess cerumen? |
| 3. Mouth/Throat | | | Dentures? Poor dentition? Ulcers? Erythema? |
| 4. Neck | | | Lymph nodes? Thyroid? Bruit? |
| 5. Lungs | | | Wheezes? Rales? Diminished breath sounds? |
| 6. Heart | | | Murmur? Irregular rhythm? |
| 7. Abdomen | | | Masses? Tenderness? Organomegaly? Hernia? Prostate? Stool guaiac? |
| 8. Musculo-skeletal | | | Clubbing? Edema? Deformity? Spine? Varicosities? Gait? Weakness? Atrophy? Decreased ROM? |
| 9. Neurologic | | | Reflexes? Motor? Sensory? Cranials? |
| 10. Skin | | | Scars? Moles? Rashes? Erythema? Excoriation? Scaling? Tattoos? |

I certify that I have reviewed the examination form and performed a physical examination on this patient.

Examiner's Signature: _____ Date: _____

Title of Examiner: _____

A referral has been made for further evaluation to: _____

Comments: