

Firefighter History and Physical Form

All information is confidential and will not be released without your knowledge and consent. If you have any questions or information which may be helpful, please attach a separate page with information.

NAME: _____ SS# _____ Male ___ Female

Address: _____ DOB _____
Street City State

Home phone: _____ Cell phone: _____ Work phone: _____

Please complete the following. A positive response on any of the items will not necessarily preclude the candidate from participating in firefighting activities.

FAMILY HISTORY

	Age	State of Health	Age, Cause of death	What relative has or has had:	
Father				Tuberculosis	
Mother				Diabetes	
Brother				Kidney disease	
Brother				Heart disease	
				Asthma, Hay fever	
				Cancer	
Sister				High blood pressure	
Sister				Epilepsy	

PERSONAL HISTORY (Please answer all questions)

Have you had or are you concerned about?	Yes	No		Yes	No		Yes	No
Alcohol use			Heart palpitation			Sinusitis		
Asthma, Hay fever			Hepatitis			Stomach trouble		
Back problem			High blood press.			Suicidal thoughts		
Cancer, cyst			HIV			Trouble sleeping		
Chemical dependency			Jaundice			Tuberculosis		
Chest pain pressure			Joint injury/disease			Urinary problems		
Chronic cough			Malaria			Venereal disease		
Diabetes			Measles			Weakness/paralysis		
Dizziness/Fainting			Measles(German)					
Ear/nose/throat trouble			Mononucleosis			Females:		
Eating disorder			Mumps			Irregular periods		
Epilepsy/seizures			Pneumonia			Severe cramps		
Eye trouble			Polio			Excessive flow		
Frequent anxiety			Recent wt gain/loss			Pregnancy		
Frequent depression			Recurrent colds					
Frequent indigestion			Recurrent diarrhea			Other conditions:		
Gallbladder trouble			Recurrent headache					
Gum/Tooth trouble			Rheumatic fever					
Head injury			Scarlet fever					
Heart murmur			Shortness of breath					

	YES	NO	Please explain any "yes" answers
Have you had any illness or injury or surgery which required hospitalization?			
Have you consulted or been treated by clinic, physician, or other practitioners in the last 5 years?			
Has a doctor ever said you have a heart condition or high blood pressure and recommended only medically approved activity?			
Have you developed chest pain at rest in the past month?			
Do you lose consciousness or lose your balance as a result of dizziness?			
Do you have a bone or joint problem that could be aggravated by physical activity?			
Do you have any neurologic condition such as epilepsy or seizures?			
Are you aware, through your own experience or through a doctor's advice, of any other physical reason against you exercising without medical supervision?			
Have you been rejected or discharged from military service because of physical or emotional difficulties which require professional attention?			
Do you have any personal or emotional difficulties which require professional attention?			
Do you have any physical, mental, or medical condition which may limit your full participation in any classes or activities in the fire company?			
Are you now under treatment or medication for any medical or emotional condition?			

ALLERGIES

Do you have any allergies?	Yes	No
Please list allergies below:		

MEDICATIONS

Do you take any medications? (If yes, please list below)	Yes	No

Do you smoke? ____ Yes ____ No _____ Packs per day ____ Number of years

Do you drink alcohol? ____ Yes ____ No _____ Number of drinks per day

PHYSICAL EXAMINATION

Height _____ Weight _____ BMI _____ Pulse _____ BP _____ Temp _____

Repeat BP _____

Visual acuity: _____ R _____ L (Distant) _____ R _____ L (Near)

Corrected _____ Yes _____ No

Color (Ishihara) _____ Normal _____ Red green deficiency

Are there any abnormalities of the following systems?

	Yes	No
HEENT		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Genitourinary		
Metabolic/endocrine		
Neurologic		
Psychiatric		
Skin		
Neck/Back		
Upper extremities		
Lower extremities		
Other		

LABORATORY

Spirometry	FVC		FEV1		FVC/FEV1		PEF	
Cholesterol	Total		HDL		LDL		Ratio	
Triglycerides			Glucose				Hep B	
CBC	Normal							
CMP	Normal							

AUDIOMETRY 500 Hz 1000Hz 2000 Hz 3000 Hz 4000 Hz 6000 Hz 8000 Hz

Left							
Right							

SUMMARY: _____

RECOMMENDATIONS: _____

Provider

Date