

SHC Corporate Health Fire Fighter Annual Patient Health Review

		Today's Da	ite:/
Personal Information:			
Legal Name:			
(Last)	(First)		(M.I.)
AKA or Nickname:	(= = 1)		(=-=)
Date of Birth:/ Se	x: M / F		
Employee ID#			
Marital Status:			
Address:			
City:	St	ate:	Zip:
Work Phone:			-
Best Time To Contact You:			
Employer Information:			
Name of Home Department:			
Specify:			te: / /
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:	St	ate:	Zip:
Personal Family Physician Information	on:		
Personal Physician:	P	hone:	
Address:			
City:	St	ate:	Zip:
Education Years: (Check highest leve	<u>l)</u>		
☐ High School ☐ AA ☐ BA/BS	☐ MA/MS ☐	Other (Specify):
Past Medical Problems/Hospitalizatio	ons:		
Since your last exam, have you been he	ospitalized?	Yes Yes	☐ No
If yes, please provide details:			
Date(s): Reas	son:		

	If yes, please provide dates and reasons for surgery: Date(s): Reason:										
S	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				Fainting Spells				Personality Change	
		Allergies				Fever				Prostate Symptoms	
		Anemia				Fractures (Broken Bones)				Sexual Problems	
		Arm or Leg Pain				Gall Bladder/Stones				Sickle Cell Disease/Trait	
		Arthritis				Hair loss				Sinus Trouble	
		Back Pain or Trouble				Headache				Skin Problem	
		Blood Loss				Heat injury				Stress Problems	
		Blood Pressure				Hemorrhoids/Piles				Testicular Pain/Problems	
		Bone/ Joint Deformity				Hepatitis or Liver Trouble				Thyroid Disease	
		Bowel Problems				Hernia				Tremor/shake	
		Breast – Mass/Pain/Problems				Indigestion				Positive TB skin test	
		Bronchitis				Insomnia				Tumors or cysts	
		Cancer				Joint Pain/problem				Ulcers	
		Chest Pain				Kidney stones				Unexpected Weight Change	
		Chicken Pox				Leg cramps				Urinary Trouble	
		Chronic Cough				Lung or Breathing problems				Varicose Veins	
		Cold or Painful Fingers				Memory Loss				Venereal Disease	
		Tooth or Gum Problems				Migraine					
		Depression or Excessive Worry				Muscle Ache/Pain					
		Dizziness				Nervousness					
		Yes No									
		☐ ☐ Have yo	u ever had	d an e	ye e	xam by a specialist?	When wa	s you	r las	t exam?	
		☐ ☐ Have you	ı ever bee	n tolo	l tha	t you had glaucoma?					

	Yes	No	
			Have you used any inhaled medications (aerosolized inhaler) in the past hour?
			Have you eaten a heavy meal in the past hour?
	Г	1 [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?
	Has your ☐ Yes		oyer told you how to contact the health care professional who will review this questionnaire?
2.	Check th	e type	of respirator you will use (you can check more than one category):
	□ N, R,	or P d	isposable respirator (filter-mask, non-cartridge type only)
			for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained
	breathing		
3.	Have you	u worn	a respirator: Yes No If yes, what type(s):
	T 7	3.7	
1.	Yes	<i>No</i> □	Do you currently smoke tobacco, or have you smoked tobacco in the last month?
2.	Have	_	er 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 ev	er had any of the following pulmonary or lung problems?
	Yes	No	
a.			Asbestosis
b.			Asthma
c.			Chronic bronchitis
d.			Emphysema
e.	=	$\overline{\sqcap}$	Pneumonia
f.	_	\sqcap	Tuberculosis
g.	=		Silicosis
*h.	_		Pneumothorax (collapsed lung)
i.	_		Lung cancer
*j.	=		Broken ribs
*k.			Any chest injuries or surgeries
	=		
1.	_	⊔ 	Any other lung problem that you've been told about
4.	•		ently have any of the following symptoms of pulmonary or lung illness?
	Yes	No	Shortness of breath
a.	_		
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
1.	\Box		Wheezing that interferes with your job
m.		$\overline{\sqcap}$	Chest pain when you breathe deeply
n.	$\overline{\Box}$	$\overline{\sqcap}$	Any other symptoms that you think may be related to lung problems
5.	Have	vou ev	er 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.	\Box	$\overline{\sqcap}$	Any other heart problem that you have been told about
6.	Have	you ev	er 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 yo	u curr	ently take medication for any of the following problems?
	Yes	<u>No</u>	
a.			Breathing or lung problems
b.			Heart trouble
c.			Blood pressure
d.			Seizures (fits)
8.			ised a respirator, have you ever had any of the following problems? If you have never used a respirator, lowing space and go to next question: Never used a respirator
	Yes	No	
a.			Eye irritation
b.	Ц		Skin allergies or rashes
c.	닏		Anxiety
d.			General weakness or fatigue
e.			Any other problem that interferes with your use of a respirator
9.	Would question	•	ike to talk to the health care professional who will review this questionnaire about your answers to this e?
	<u>Yes</u>	<u>No</u>	
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.

11. D	o you curre	ently 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
	-	rently have any of the following hearing problems?
	Yes No	Difficulty bearing
;		Difficulty hearing
b.		Wear a hearing aid
*c.		Draining or painful ear Ear infection
*d. [Any other hearing or ear problem
e. [Have you ever had a back injury
	∟	rently have any of the following musculoskeletal problems?
	Yes No	enay nave any of the following intocuroskeletta problems:
		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
		m, have you developed any new medical problems (not listed above)? s, provide details: Date(s): Description:
Habits: Yes No □ □	Do you dr	ink alcoholic beverages?
	If yes, answ	wer the following: (One drink + 1 bottle of beer, 1 glass of wine, or 1 drink of liquor).
	•	drinks do you drink each week?
	-	
пп	Do you sn	noke or use tobacco?
	How many	do you smoke/chew? Cigarettes/d Cigars/d Cans/w Pipes/d _
	,	
		you a former smoker or tobacco user ?

<u>Fitn</u>	ess R	<u>leview:</u>
		t your exercise activities and number of times per week you perform each.
Aero	obic king	X per week in the past month
		Z per week in the past month X per week in the past month
Othe		
Sinc	e you	ur last exam, compare your activity level:
		ive EMS/Fire Experience:
		he # of years in each position(s):
Fire	rignte	r Engineer Captain BC Admin
Sele	ct the	type of respirator(s) you used: SCBA MP5 Other
Hav or h	e you ave co	onal Exposures: had any work related exposures to fires of HAZMAT situations where you have developed health changes oncerns about your health? Yes No ovide details:
Vac	No	
<i>Yes</i>		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?
	П	Do you have a prior occupation? If yes, please list.
		Have you been in the military services:
		·
ш	Ш	If yes, were you exposed to biologic or chemical agents (in either training or combat)
_	_	If yes, please identify the agent
Ш	Ш	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?
\Box		Do you use any chemicals/ materials in your hobbies(or solvents, solder, pesticides, lead or other metals

If yes, provide details		
	ry Past Job ent Ear Problem	
Medication Review: List any drugs (by name) you have taken reand non-prescription (over the counter medication)		
Have you had any difficulties having child Abortion)? If yes, provide details below:	Yes	ous No
Employee Name - Printed	Employee Signature	Date
Physician Reviewing Medical Evaluation Name - Printed	Physician Reviewing Medical Evaluation Signature	Date