Bassett Healthcare Network
HealthWorks

FIREFIGHTER/EMS MEDICAL CLEARANCE EVALUATION

Fire Company: _____ Today's Date: _____

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Last 4 of Social Security #: _____

Race: (check only one):

☐ White ☐ Black ☐ Hispanic ☐ Native American ☐ Asian ☐ Mixed ☐ Unknown

Country of Birth: ☐ USA ☐ Other _____
(Specify)

Highest Level of Education:

☐ Elementary ☐ High School ☐ 2 Yr. College ☐ 4 Yr. College ☐ Graduate School

Mailing Address:_____

_____

E-Mail Address:_____

Phone Number: _____

Practitioners Name:_____

Practitioners Address/Location:_____

☐ Unless you indicate otherwise, only abnormal findings will be shared with your practitioner. Check here to request additional records to be sent. Please Specify:_____

Medical Record Release obtained: ☐ Yes ☐ No

Would you allow the NYS Department of Health to contact you for future studies? ☐ Yes ☐ No

Bassett Healthcare Network
HealthWorks

Name:_____ **Date of Birth:**_____ **Date of Service:**_____

FIREFIGHTER/EMS
MEDICAL HISTORY QUESTIONNAIRE

Medical History

Since your last physical exam with us (or in the last year), have you consulted a doctor? Practitioner's Name:	No	Yes	Why?
Since your last physical exam with us (or in the last year), have you been hospitalized? Name of Hospital:	No	Yes	Why?
Have you ever had problems performing any other part of your job or duties?	No	Yes	Explain:
List any recent (in the last year) illnesses, previous injury or surgery/operation:			
List ANY prescription medications you are taking:			
List ANY over-the-counter medications you are taking:			
Indicate any job related illness or injuries you have experienced since working in present job:			
Have you ever noticed that any chemical or other substance makes you cough, be short of breath, or wheeze?	No	Yes	
Do you presently exercise for 20 minutes or more at least 3 days per week?	No	Yes	
Do you drink alcohol of ANY TYPE?	No	Yes	What type?
How much or how often?	Per Week	How Long?	Years
Have you quit?	No	Yes	How long ago?
Do you currently smoke?	No	Yes	How many: Packs/day____ Cigars/day___ Pipes/Day_____ Vape Cartridge/Day____
Have you quit smoking?	No	Yes	How much did you smoke: Packs/day____ Cigars/day___ Pipes/Day_____ Vape Cartridge/Day____
How many years did you smoke:_____	What Year did you quit? _____		

Family History

Have you had a parent, brother or sister who has had heart disease before age 60? (If yes, please provide age of relative and condition)	No	Yes	

Have you ever had any of the following conditions?	No	Yes	When?
Seizures (fits)			
Diabetes (sugar disease)			
Allergic reactions that interfere with your breathing			
Asthma			
Emphysema			
Tuberculosis			

Have you ever had any of the following cardiovascular or heart problems?	No	Yes	When?
Heart Attack			
Stroke			
Angina			
Heart failure			
Swelling in your legs or feet (not caused by walking)			
Heart arrhythmia (heart beating irregularly)			
High blood pressure			
Frequent pain or tightness in your chest			
Pain or tightness in your chest during physical activity			

Do you currently have any of the following symptoms of pulmonary or lung illness?	No	Yes	When?
Shortness of breath			
Shortness of breath when walking fast on level ground or walking up a slight hill or incline:			
Coughing that produces phlegm (thick sputum)			
Coughing up blood in the last month			
Wheezing			
Any other symptoms that you think may be related to lung problems :			

Have you ever experienced?	No	Yes	When?
Head injury / Concussion			
Nerve injury			
Fainting/Loss of Consciousness			
Numbness			
Dizziness/Lightheadedness			
Frequent headaches			
Other loss of function (specify)			
Other neurologic disorders (specify)			
Sinus troubles			
Nosebleeds or other nose troubles			
Sore, burning, or itchy throat or nose when at work			
Burning, tearing, swollen or redness in eyes, eyelids, or face when at work			
Tooth or gum problems			
Difficulty swallowing			
Problems with digestion			
Persistent nausea			
Vomiting			
Abdominal pain / cramping			
Change in bowel habits			
Ulcer			
Hiatus hernia			
Gall bladder problem			
Jaundice			
Liver problems, hepatitis, or cirrhosis			
Blood in stool / black or red stool			
Recurrent diarrhea			
Chronic constipation			
Frequent urination			
Burning when urinating			
Sensation of need to urinate, but not able to			
Difficulty starting / stopping urinary system			
Blood in urine			
Kidney stone			
Sugar in urine			
Hernia			

Have you ever experienced?	No	Yes	When?
Discharge from genitals / breasts			
Varicose veins			
Skin rash / itching / allergy			
Lump in skin / breast / genitals			
Cancer or tumors (specify)			
Anemia			
Unusual bleeding / clotting problem / tendency to bruise easily			
Problems with your spleen			
Swelling or lumps in your breast, neck, armpits, groin or elsewhere			
Frequent night sweats			
Recurrent fevers			
Thyroid problems / disease			
Psoriasis / Eczema			
Contact dermatitis			
Other skin disorders (specify)			
Heat injury / illness			
Been a patient of a psychiatrist			
Been a patient in a psychiatric hospital			
Worry all the time			
Have difficulty concentrating			
Regard yourself as being nervous			
Feel depressed or “blue” most of the time			
Become irritated or upset easily			
Had a nervous breakdown			
Use any drug/other substances not authorized by a Licensed Medical Professional			
Women Only:			
Has your menses ceased?			
Are you currently pregnant?			

<u>All volunteers need to complete and sign below</u>:

Do you have any physical complaints today or any other health conditions or concerns not covered by these questions? ☐ YES ☐ NO

All of my answers above are true and accurate. To the best of my knowledge, I currently have no uncontrolled mental health problem, physical health problem, infectious disease, or any health impairment, which represent a potential risk in my patient care or firefighter/EMS responsibilities.

_____

Firefighter/EMS

Bassett Healthcare Network
HealthWorks

Firefighter/ EMS Physical Examination Form

Name: _____ Date of Service: _____

Date of Birth: _____ Age: _____ Last 4 of Social Security #:_____

**********STOP HERE**********

Current Firefighter/ EMS Classification	A	B	C	D
Preferred Classification:	A	B	C	D
Medical Clearance Classification:				
Firefighter	A	B	C	D
EMS		B	C	D
Medically Cleared to wear SCBA	YES	NO		
Medically Cleared to wear N95	YES	NO		

Notes for Chief:

Vital Signs:

Height: _____ in. Weight: _____ lbs.

Cuff size (circle) Pediatric Regular Large Adult Large Long X-Large/Bariatric

Blood Pressures	Time	Arm	Reading	Heart Rate
Manual/ Automated	____	R / L	_____/_____	_____
Manual/ Automated	____	R / L	_____/_____	_____
Manual/ Automated	____	R / L	_____/_____	_____

☐ **BP Letter given if > 140/90**

Vision: ☐ Contact lenses used

Distance: 20/_____(Without Correction) 20/_____(With correction)

Peripheral vision: (without correction) Right eye: 85 70 55 Left eye: 85 70 55

☐ Has SCBA inserts ☐ Snellen Chart used

Normal Abnormal

Pulmonary Function Test/ Spirometry: Normal Abnormal

☐ Has a smoking history ☐ Used an inhaler in the last hour ☐ Any injuries to chest or lungs in the past 6 mos.
☐ Eaten in a big meal ☐ Currently has a cold

EKG: Normal Abnormal ☐ Please Send EKG to Primary Care Provider

Physical Exam: Normal Borderline Abnormal

Cardiovascular Risk Profile: (Class A&B- 45 and older)

Respiratory Fit:

☐ OSHA FORM Completed and Reviewed
☐ Education Provided and individual verbalized understanding of instruction

SCBA Disposable N95

_____ _____ (Brand) (Size)

_____ _____ (Brand) (Size)

Name:_____ Date of Birth: _____

PHYSICAL EXAMINATION

	Normal	Abnormal	Comments
HEENT Tympanic membranes/canals			Hearing aids: Yes No
Hearing **(whisper test)**			
Eyes: Cornea, EOM, Pupils			
Neck			
Lymph nodes			
Thyroid			
CHEST Breath sounds			
Heart rhythms (note abnl rate)			
Heart size			
Heart sounds/murmurs			
ABDOMEN Contour			
Organ size			
Tenderness			
Masses			
GENITAL Genitourinary systems			
Hernias			
EXTREMITIES Nails: Cyanosis/clubbing			
Edema			
Deformities			
Handicaps			
Blood vessels			
NEUROLOGICAL Reflexes			
Sensory			
Motor/Gait			
Balance			
OTHER			
SKIN			

COMMENTS:	Counseled	Issues:
_____	○	_____
_____	○	_____
_____	○	_____
_____	○	_____
_____	○	_____

Provider Signature: _____ EKG Reviewed _____

Date: _____