Bassett Healthcare Network
Healthworks
Occupational Health Services

FIREFIGHTER/EMS MEDICAL CLEARANCE EVALUATION

Fire Company: ______________________________ Date: ____________________

Name: ____

Social Security #: __________ ________ __________

Race: (Check only one):

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

Date of Birth: ______________ Age: __________ Sex: __________

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: ____

Home Phone: ( ) ____

Doctor's Full Name: ____

Address: ____

____

☐ Unless you indicate otherwise, only abnormal findings will be shared with your provider. Check here to request additional records. Please specify: ______________________________________

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

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Name:______________________________ **Date:**_______________

FIREFIGHTER/EMS
MEDICAL HISTORY QUESTIONNAIRE

MEDICAL HISTORY

Since your last physical exam with us (or in the last year), have you consulted a doctor? Doctor'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 your 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 # of years

Have you quit smoking? NO YES How much did you smoke? packs/day cigars/day pipes/day

For how many years? What year did you quit?

FAMILY HISTORY

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

If NOT wearing a mask, complete Part A and B questions.
If wearing a mask, SKIP Part A and complete Part B questions on the back side of this page.

PART A

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			

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 had any of the following cardiovascular or heart problems?	NO	YES	WHEN?
Heart attack If Yes, when?			
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			

PART B

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, swelling 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			
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			

Have you ever experienced?	NO	YES	WHEN?
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?______________________

ALL VOLUNTEERS NEED TO COMPLETE AND SIGN BELOW:

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 represents a potential risk in my patient care or firefighter/EMS responsibilities.

____

Firefighter/EMS signature

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FIREFIGHTER/EMS MEDICAL - PHYSICAL EXAMINATION

Name: ______________________ Date: ______________ Age: ________

DOB: ______________ Social Security #: __________ - ________ - __________

•••••••••••••••••••• *STOP HERE* ••••••••••••••••••••

Current Firefighter/EMS Classification: A B C D

Classification Preferred: A B C D

Medical Clearance Classification:

Firefighter **A B C D**

EMS **B C**

Medically cleared to wear an SCBA: ☐ **Yes** ☐ **No**

Medically cleared to wear a disposable mask: ☐ **Yes** ☐ **No**

VITAL SIGNS — Complete

Height (in) __________ Weight (lbs) __________

Blood Pressure ______/______ Right arm ______/______ Right arm

______/______ Left arm ______/______ Left arm

Cuff size (circle): Pediatric Regular Large Adult Large Long Bariatric

Heart Rate (bpm) ________ Rhythm: ________ (check here only if rhythm is ***irregular***)

☐ **BP leaflet & letter given if BP is high**

VISION EXAM ______ Check (√) here if wearing contact lenses — Complete

Distance: (without corrective lenses) 20/______ **Distance**: (with corrective lenses) 20/______

Peripheral Vision (***without*** corrective lenses)

(Right eye) 85 70 55

(Left eye) 85 70 55

Normal Abnormal

PULMONARY FUNCTION TESTS (Spirometry) — Complete

☐ **OSHA FORM COMPLETED & REVIEWED**

- ☐ has a smoking history
- ☐ used an inhaler in the last hour
- ☐ eaten in the last hour
- ☐ currently has a cold

Normal Abnormal

ELECTROCARDIOGRAM (EKG) — Complete

Normal Abnormal

PHYSICIAN EXAMINATION — Complete

Normal Borderline Normal Abnormal

CARDIOVASCULAR RISK PROFILE (Class A&B - age 45 years and older) — Complete

PASS FAIL

RESPIRATORY FIT TEST — Complete

(Education provided & individual verbalized understanding of instructions) ______ **Yes** ______ **No**

SCBA Mask __________ (Brand) __________ (Size) Disposable Mask __________ (Brand) __________ (Size)

Name: ______________________________ DOB: ____________________

PHYSICAL EXAMINATION

	Normal	Abnormal	Comments
HEENT Tympanic membranes/canals			
Hearing			
Eyes: Cornea, EOM, Pupils			
Neck			
Lymph nodes			
Thyroid			
CHEST Breath sounds			
Heart rhythms (note abnormal rate)			
Heart size			
Heart sounds/murmurs			
ABDOMEN Contour			
Organ size			
Tenderness			
Masses			
GENITAL/RECTAL Genitourinary systems			
Hernias			
Optional rectal			
EXTREMITIES Nails: Cyanosis/clubbing			
Edema			
Deformities			
Handicaps			
Blood vessels			
NEUROLOGICAL Reflexes			
Sensory			
Motor/Gait			
Other			
SKIN			

COMMENTS:

______________________________ **ISSUES:** 1. ____________________ **Counseled** ☐

______________________________ 2. ____________________ **Counseled** ☐

______________________________ 3. ____________________ **Counseled** ☐

______________________________ 4. ____________________ **Counseled** ☐

Provider Signature: ______________________ Physician Signature: ______________________

Date of Examination: ______________________ **ECG Reviewed:** ☐

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