

## Medical History and Examination Form for Firefighters

<b>Clinic Performing Exam</b>		<b>Address</b>	
<b>Physician Name</b>		<b>Phone Number</b>	(865)
<b>CFNP</b>		<b>Fax Number</b>	(865)

<b>Name of Employing Agency</b>		<b>Address</b>	
<b>Department</b>		<b>Phone Number</b>	(865)
<b>Health Coordinator</b>		<b>Fax Number</b>	(865)

<b>Candidate</b>		<b>Address</b>	
<b>Position / Job Title</b>		<b>Phone Number</b>	
<b>Date of Birth</b>		<b>Age</b>	
		<b>Sex</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female
			<b>Social Security Number</b>

Incomplete forms or missing information may result in a delay clearing you for firefighter duties. Submitting information that is misleading or untruthful may result in termination, criminal sanctions, or failure to be cleared for duty.

This history form and review does not substitute for routine health care or a periodic health examination conducted by your physician. It is being conducted for occupational purposes only. I certify that all the information I have provided on this form is complete and accurate to the best of my knowledge. I authorize release of information within this form to the Interagency Medical Standards Program Manager or their representative for the purpose of fit for duty clearance as a firefighter.

Candidate's Signature (Required): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Baseline**  Exit  Periodic Exam

- Medical History Review
- Physical Examination
- Far Vision Only (corrected and uncorrected); Color; Peripheral; Depth Perception
- Audiogram (500 Hz – 8000 Hz)
- EKG (12 lead with interpretation)
- Pulmonary Function Test (attach tracings)
- PPD test (Mantoux) – PPD placement
- PPD test (Mantoux) – PPD read
- Lab Collection – CBC, Urinalysis, Glucose, BUN, Creatinine, Liver Function, Lipid Panel, PSA
- Chest X-Ray
- Physician must sign completed exam

### PPD

1. Have you ever had a Mantoux or tuberculosis test before?  Yes  No
2. Was the test positive?  Yes  No
3. Have you ever had INH prophylaxis (preventative treatment)?  Yes  No
4. Have you ever had treatment for active TB?  Yes  No
5. Have you ever had a BCG vaccine?  Yes  No

I understand that I must return to the examining facility to have my PPD interpreted within 48-72 hours after administration.

Signature \_\_\_\_\_

Arm Given: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Given By: \_\_\_\_\_

Test results – induration (hardness): \_\_\_\_\_ mm Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature \_\_\_\_\_

# Medical History and Examination Form for Firefighters

## MEDICAL HISTORY

### Smoking History

This information is needed since tobacco use increases your risk for lung cancer and several other types of cancer, chronic bronchitis, emphysema, asbestos related lung diseases, coronary heart disease, high blood pressure, and stroke. Please check your tobacco use status and complete this section.

<input type="checkbox"/> <b>Never Smoked</b>	<b>Current Smoker</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Former Smoker</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
	Number of cigarettes per day _____ Number of cigars per day _____ Number of pipe bowls per day _____ Amount of chewing tobacco per day _____  Total years of tobacco use _____	Number of cigarettes per day _____ Number of cigars per day _____ Number of pipe bowls per day _____ Amount of chewing tobacco per day _____  Total years of tobacco use _____

**Describe your Physical Activity Program**

Intensity	<input type="checkbox"/> Low	Type of Activity or Exercise	<hr/>
Examples	<input type="checkbox"/> Moderate	<input type="checkbox"/> High	Duration of minutes per session _____
	Walking	Jogging, Cycling	Frequency, in days per week _____
		Sustained heavy breathing and perspiration	

<p style="text-align: center;"><b>Medications</b></p> <p>List all medications you are currently taking, including those prescribed and over-the-counter (including herbal) as well as the reasons that you are taking them. (Use additional sheets as necessary)</p> <hr/> <hr/> <hr/>	<p style="text-align: center;"><b>Date of last Tetnus (Td) Shot:</b></p> <p style="text-align: center;">_____ / _____ / _____</p> <p style="text-align: center;"><i>Booster recommended every 10 years</i></p>
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<b>Summary of your medical history</b>	<b>Allergies</b>
<hr/> <hr/> <hr/>	<hr/> <hr/> <hr/>

*Examiner: Use this space to comment on positive history or findings on this page*

## Medical History and Examination Form for Firefighters

### MEDICAL HISTORY

**Note: For every item checked “Yes” provide dates, treatments, and current status. Use the blank spaces below.**

A. Have you ever been treated with an organ transplant, prosthetic device (e.g. artificial hip), or an implanted pump (e.g. for insulin) or electrical device (e.g. cardiac defibrillator)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
B. Have you had or have you been advised to have an operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
C. Have you ever been a patient in any type of hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
D. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past year for other minor illnesses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
E. Have you been rejected for military service because of physical, mental, or other reasons?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
F. Have you ever been treated for a mental or emotional condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
G. Have you ever been diagnosed with or treated for alcoholism or alcohol dependence?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
H. Have you ever been diagnosed as being dependent on illegal drugs, or treated for drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
I. Have you ever received, is there pending, or have you applied for a pension or compensation for a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
J. Do you have any allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
K. Are you allergic to any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

*Examiner: Use this space to comment on positive history or findings on this page:*

# Medical History and Examination Form for Firefighters

**Vision** Yes No

Any eye disease

Do you wear eyeglasses    
 far  near  both

Do you wear contact lenses    
 hard  soft

Do you have a history of frequent headaches

Blurred vision

Difficulty reading

Glaucoma

Cataracts

Color blindness

*Please explain any YES answers, including dates:*

\_\_\_\_\_

\_\_\_\_\_

**Head and Neck**

NL ABNL

Head, Face, Neck (thyroid), Scalp

Nose / Sinuses / Eustachian tube

Mouth / Throat

Pupils equal / reactive

Ocular motility

Ophthalmoscopic findings

Speech

**Otosopic Exam**

	Right		Left	
	NL	ABNL	NL	ABNL
Canal / External Ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tympanic Membrane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Hearing** Yes No

Any ear disease

Loud, constant noise or music in the last 14 hours

Loud, impact noise in the last 14 hours

Ringing in the ears

Difficulty hearing

Ear infections or cold in the last 2 weeks

Dizziness or balance problems

Eardrum perforation

Use of a hearing aid     
 Left  Right  Both

Use of protective hearing equipment when working around loud noise    
 foam  pre-mold/plugs  ear muffs

*Please explain any YES answers, including dates:*

\_\_\_\_\_

\_\_\_\_\_

**Audiogram** (Attach Printout)

Type of Test:

Baseline

Periodic

Exit

Calibration Method:

Oscar  Biological Date \_\_\_/\_\_\_/\_\_\_

*Hearing must be done without hearing aid, and must meet OSHA standard for testing*

Frequency	500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz	8000 Hz
Right Ear dB @							
Left Ear dB @							

Verify Audiogram if >40 dB for 5k, 1k, 2k, or 3k  Audio verified

**Vision** (Must complete A and B)

*Color Vision A:*

Type of  Ishihara plate (# of plates = \_\_\_\_\_)

OPTEC 2000 Vision Tester

Titmus Vision Tester

Farnsworth D-15

Other (specify) \_\_\_\_\_

Number Correct \_\_\_\_\_ of \_\_\_\_\_ tested

*Color Vision B: (Red, Green, and Yellow) (Ishihara does not test for yellow)*

Able to see red / green / yellow?  Yes  No

Type of test: \_\_\_\_\_

Clinician, please use a qualitative testing method

*Far Vision Acuity: (Near vision not required)*

Uncorrected

Right 20 / \_\_\_\_\_ Left 20 / \_\_\_\_\_ Both 20 / \_\_\_\_\_

*Only soft contact lens wearers do not need uncorrected vision recorded*

Corrected

Right 20 / \_\_\_\_\_ Left 20 / \_\_\_\_\_ Both 20 / \_\_\_\_\_

*Peripheral Vision: Right \_\_\_\_\_° Left \_\_\_\_\_°*

*Depth Perception:*

Type of test:

Stereo Numbers: Number Correct: \_\_\_\_\_ of \_\_\_\_\_ tested

Stereo Animals: \_\_\_\_\_ seconds of arc

\_\_\_\_\_ % Shepard Frye

Other: type of test Response: \_\_\_\_\_ seconds of arc

*Examiner: Use this space to comment on positive history or findings on this page:*

\_\_\_\_\_

\_\_\_\_\_

## Medical History and Examination Form for Firefighters

<b><u>Vascular</u></b>	<b>Yes</b>	<b>No</b>
Any vascular disease	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged superficial veins, phlebitis, or blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Hardening of the arteries	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Stroke or Transient Ischemic Attack (TIA)	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysms	<input type="checkbox"/>	<input type="checkbox"/>
Poor circulation to hands and feet	<input type="checkbox"/>	<input type="checkbox"/>
White fingers with cold / vibration	<input type="checkbox"/>	<input type="checkbox"/>

<b><u>Respiratory</u></b>	<b>Yes</b>	<b>No</b>
Any respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma (including exercise induced asthma)	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis or Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Excessive, unexplained fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Use of inhalers	<input type="checkbox"/>	<input type="checkbox"/>
Acute or chronic lung infection	<input type="checkbox"/>	<input type="checkbox"/>
Collapsed lung	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis (curved spine) with breathing limitations	<input type="checkbox"/>	<input type="checkbox"/>
History of Tuberculosis (Date: ____ / ____ / ____)	<input type="checkbox"/>	<input type="checkbox"/>

<b><u>Heart</u></b>	<b>Yes</b>	<b>No</b>
Any heart disease or heart murmurs	<input type="checkbox"/>	<input type="checkbox"/>
Heart or chest pain (angina) with or without exertion	<input type="checkbox"/>	<input type="checkbox"/>
Heart rhythm disturbance or palpitations	<input type="checkbox"/>	<input type="checkbox"/>
History of Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Organic heart disease (including prosthetic heart valves, mitral stenosis, heart block, heart murmur, mitral valve prolapse, pacemakers, implanted defibrillator, WPW, etc.	<input type="checkbox"/>	<input type="checkbox"/>
Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>
Sudden loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>

*Please explain any YES answers, including dates:*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Cardio/Pulmonary Assessment**

NL ABNL

Lungs / Chest

Heart (thrill, murmur)

Major blood vessels

Peripheral blood vessels

Resting 12 lead EKG (Supine Only)  
*(Attach with signed interpretation)*

Chest X-Ray

*Please explain any ABNL answers, including dates:*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Coronary Risk Factors**

Blood Pressure > 140/90	Yes	No
Diabetes or Fasting Glucose > 126 mg/dl	<input type="checkbox"/>	<input type="checkbox"/>
Total Cholesterol > 200 mg/dl or HDL > 40 mg/dl	<input type="checkbox"/>	<input type="checkbox"/>
Family history of CVD in males <55	<input type="checkbox"/>	<input type="checkbox"/>
Age (men > 45, women > 55)	<input type="checkbox"/>	<input type="checkbox"/>
No regular exercise program	<input type="checkbox"/>	<input type="checkbox"/>
Current smoker	<input type="checkbox"/>	<input type="checkbox"/>

*Please explain any YES answers, including dates:*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Vital Signs**

Height \_\_\_\_\_ (in.) Weight \_\_\_\_\_ (lbs)

Resp. \_\_\_\_\_ / min Temp. \_\_\_\_\_

Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ (sitting)

Pulse \_\_\_\_\_ / min  Regular  Irregular

*If blood pressure is > 180/100 repeat after 10-15 minutes*

**Spirometry** (3 good attempts required)  
(Attach all 3 tracings)

Technician ID: \_\_\_\_\_

Calibration Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Daily calibration performed:  yes  no

Machine Make / Model: \_\_\_\_\_

Examinee effort:  Good  Fair  Poor

Actual FVC	Actual FEV1	Actual FEV 1/FVC	Actual FEF 25-75
% Predicted FVC	% Predicted FEV 1	% Predicted FEV 1/FVC	% Predicted FEF 25-75

*Examiner: Use this space to comment on positive history or findings on this page:*

## Medical History and Examination Form for Firefighters

<p><b><u>Endocrine</u></b> <span style="float: right;"><b>Yes</b> <b>No</b></span></p> <p>Any endocrine disease <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Thyroid disease <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Obesity <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Unexplained weight loss or gain <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Diabetes (Insulin requiring) <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span>              If yes, units per day _____. Year diagnoses _____</p> <p>Diabetes (Non-insulin requiring) <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span>              Year diagnosed _____</p> <p>If you have diabetes              Current medications: _____</p> <p>Last hemoglobin A1c _____% date performed _____</p> <p>Have you ever had a hypoglycemic episode <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span>              If yes, last date _____</p> <p>Have you ever been hospitalized for diabetes <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span>              If yes, dates _____, _____, _____</p>	<p><i>Examiner: Use this space to comment on positive history or findings on this page:</i></p>																					
<p><b><u>Gastrointestinal</u></b> <span style="float: right;"><b>Yes</b> <b>No</b></span></p> <p>Any gastrointestinal disease <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Hernias <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Colostomy <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Persistent stomach / abdominal pain / active ulcer <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Hepatitis or other liver disease <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Irritable bowel syndrome <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Rectal bleeding <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Vomiting <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p>	<p><b><u>Gastrointestinal Assessment</u></b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 10%;"><b>NL</b></td> <td style="width: 10%;"><b>ABNL</b></td> <td style="width: 10%;"><b>Yes</b></td> <td style="width: 10%;"><b>No</b></td> <td style="width: 50%;"></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Auscultation</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Organomegaly</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Palpation</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Tenderness</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Hernia</td> </tr> </table> <p style="text-align: center;">(Specify type: _____)</p>	<b>NL</b>	<b>ABNL</b>	<b>Yes</b>	<b>No</b>		<input type="checkbox"/>	<input type="checkbox"/> Auscultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Organomegaly	<input type="checkbox"/>	<input type="checkbox"/> Palpation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Tenderness			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hernia	<p><i>Examiner: Use this space to comment on positive history or findings:</i></p>
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<p><b><u>Genitourinary</u></b> <span style="float: right;"><b>Yes</b> <b>No</b></span></p> <p>Any genitourinary disease <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Blood in urine <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Kidney stones <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Difficult or painful urination <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></p> <p>Infertility (difficulty having children) <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span>              Please explain any YES answers, including dates:              _____              _____              _____</p>	<p><b><u>Genitourinary Assessment</u></b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 10%;"><b>NL</b></td> <td style="width: 10%;"><b>ABNL</b></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 50%;"></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> External genitalia</td> <td></td> <td><input type="checkbox"/></td> <td>Deferred</td> </tr> </table> <p style="text-align: center;"><i>Note: this clearance exam does not require a pelvic exam or PAP smear for females, or a rectal or prostate exam for males</i></p>	<b>NL</b>	<b>ABNL</b>				<input type="checkbox"/>	<input type="checkbox"/> External genitalia		<input type="checkbox"/>	Deferred	<p><i>Examiner: Use this space to comment on positive history or findings:</i></p>										
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<p><b><u>Musculoskeletal</u></b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 70%;">Any musculoskeletal disease</td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 20%; text-align: center;">No</td> </tr> <tr> <td>Moderate to severe joint pain, arthritis, tendonitis</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Amputations</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Loss of use of arm, leg, fingers, or toes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Loss of sensation</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Loss of strength</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Loss of coordination</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Chronic back pain</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Chronic back pain associated with leg numbness, weakness, or pain</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Back surgery within last 2 years</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p>Are you <input type="checkbox"/> right handed <input type="checkbox"/> left handed</p> <p style="text-align: center;"><i>Please explain any YES answers, including dates:</i></p> <p>_____</p> <p>_____</p> <p>_____</p>	Any musculoskeletal disease	Yes	No	Moderate to severe joint pain, arthritis, tendonitis	<input type="checkbox"/>	<input type="checkbox"/>	Amputations	<input type="checkbox"/>	<input type="checkbox"/>	Loss of use of arm, leg, fingers, or toes	<input type="checkbox"/>	<input type="checkbox"/>	Loss of sensation	<input type="checkbox"/>	<input type="checkbox"/>	Loss of strength	<input type="checkbox"/>	<input type="checkbox"/>	Loss of coordination	<input type="checkbox"/>	<input type="checkbox"/>	Chronic back pain	<input type="checkbox"/>	<input type="checkbox"/>	Chronic back pain associated with leg numbness, weakness, or pain	<input type="checkbox"/>	<input type="checkbox"/>	Back surgery within last 2 years	<input type="checkbox"/>	<input type="checkbox"/>	<p><b><u>Musculoskeletal Assessment</u></b></p> <p>NL ABNL</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 10%;"><input type="checkbox"/></td> <td style="width: 10%;"><input type="checkbox"/></td> <td>Upper extremities (Strength)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Upper extremities (Range of motion)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Lower extremities (Strength)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Lower extremities (Range of motion)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Feet</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hands</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Spine, other musculoskeletal</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Flexibility of neck, back, spine, hips</td> </tr> </table> <p style="text-align: center;"><i>Please explain any ABNL answers, including dates:</i></p> <p>_____</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/>	<input type="checkbox"/>	Upper extremities (Strength)	<input type="checkbox"/>	<input type="checkbox"/>	Upper extremities (Range of motion)	<input type="checkbox"/>	<input type="checkbox"/>	Lower extremities (Strength)	<input type="checkbox"/>	<input type="checkbox"/>	Lower extremities (Range of motion)	<input type="checkbox"/>	<input type="checkbox"/>	Feet	<input type="checkbox"/>	<input type="checkbox"/>	Hands	<input type="checkbox"/>	<input type="checkbox"/>	Spine, other musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	Flexibility of neck, back, spine, hips	<p style="text-align: center;"><i>Examiner: Use this space to comment on positive history or findings on this page:</i></p>
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<p><b><u>Neurological</u></b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 70%;">Any neurological disease</td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 20%; text-align: center;">No</td> </tr> <tr> <td>Tremors, shakiness</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Seizures (current or previous)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Spinal cord injury</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Numbness or tingling</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Head / Spine surgery</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>History of head trauma with persistent problems</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Chronic or recurring headaches (migraines)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>History of brain tumor</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Loss of memory</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Insomnia (difficulty sleeping)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p style="text-align: center;"><i>Please explain any YES answers, including dates:</i></p> <p>_____</p> <p>_____</p> <p>_____</p>	Any neurological disease	Yes	No	Tremors, shakiness	<input type="checkbox"/>	<input type="checkbox"/>	Seizures (current or previous)	<input type="checkbox"/>	<input type="checkbox"/>	Spinal cord injury	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>	Head / Spine surgery	<input type="checkbox"/>	<input type="checkbox"/>	History of head trauma with persistent problems	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or recurring headaches (migraines)	<input type="checkbox"/>	<input type="checkbox"/>	History of brain tumor	<input type="checkbox"/>	<input type="checkbox"/>	Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia (difficulty sleeping)	<input type="checkbox"/>	<input type="checkbox"/>	<p><b><u>Neurological Assessment</u></b></p> <p>NL ABNL</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 10%;"><input type="checkbox"/></td> <td style="width: 10%;"><input type="checkbox"/></td> <td>Cranial nerves (I-XII)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cerebellum</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Motor / Sensory (Including vibratory and proprioception)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Deep tendon reflexes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Mental status exam</td> </tr> </table> <p style="text-align: center;"><i>Please explain any ABNL answers, including dates:</i></p> <p>_____</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/>	<input type="checkbox"/>	Cranial nerves (I-XII)	<input type="checkbox"/>	<input type="checkbox"/>	Cerebellum	<input type="checkbox"/>	<input type="checkbox"/>	Motor / Sensory (Including vibratory and proprioception)	<input type="checkbox"/>	<input type="checkbox"/>	Deep tendon reflexes	<input type="checkbox"/>	<input type="checkbox"/>	Mental status exam							
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## Medical History and Examination Form for Firefighters

<p><b><u>Dermatology</u></b></p> <p>Any skin disease                    <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Sun sensitivity                      <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>History of chronic dermatitis   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Active skin disease                <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Moles that have changed in size or color   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p style="text-align: center;"><i>Please explain any YES answers, including dates:</i></p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b><u>Dermatology Assessment</u></b></p> <p>NL   ABNL</p> <p><input type="checkbox"/>      <input type="checkbox"/> Skin</p>  <p style="text-align: center;"><i>Please explain any ABNL answers, including dates:</i></p> <p>_____</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;"><i>Examiner: Use this space to comment on positive history or findings on this page:</i></p>
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*Examiner: Use this space to make additional comments about this examination:*

<b>Examining Physicians Signature</b>	<b>Examining Physicians Printed Name</b>	Date: ____ / ____ / ____
Examiner's Address		Phone Number      (865)

## Medical History and Examination Form for Firefighters

### Essential Structural Firefighting Functions

*The medical requirements in this standard were based on in-depth consideration of essential structural fire-fighting functions. These essential functions are what members are expected to perform at emergency incidents and are derived from the performance objectives stated in NFPA 1001, Standard for Fire Fighter Professional Qualifications.*

**Essential functions are performed in and affected by the following environmental factors:**

- (1) Operating both as a member of a team and independently at incidents of uncertain duration
- (2) Spending extensive time outside exposed to the elements
- (3) Tolerating extreme fluctuations in temperature while performing duties; fire fighters are required to perform physically demanding work in hot (up to 400°F), humid (up to 100 percent) atmospheres while wearing equipment that significantly impairs body-cooling mechanisms
- (4) Experiencing frequent transition from hot to cold and from humid to dry atmospheres
- (5) Working in wet, icy, or muddy areas
- (6) Performing a variety of tasks on slippery, hazardous surfaces such as on rooftops or from ladders
- (7) Working in areas where sustaining traumatic or thermal injuries is possible
- (8) Facing exposure to carcinogenic dusts such as asbestos, toxic substances such as hydrogen cyanide, acids, carbon monoxide, or organic solvents, either through inhalation or skin contact
- (9) Facing exposure to infectious agents such as Hepatitis B or HIV
- (10) Wearing personal protective equipment that weighs approximately 50 lb. while performing fire-fighting tasks
- (11) Performing physically demanding work while wearing positive-pressure breathing equipment with 1.5 in. of water column resistance to exhalation at a flow of 40 L/min
- (12) Performing complex tasks during life-threatening emergencies
- (13) Working for long periods of time, requiring sustained physical activity and intense concentration
- (14) Facing life-or-death decisions during emergency conditions
- (15) Being exposed to grotesque sights and smells associated with major trauma and burn victims
- (16) Making rapid transitions from rest to near-maximal exertion without warm-up periods
- (17) Operating in environments of high noise, poor visibility, limited mobility; at heights; and in enclosed or confined spaces
- (18) Using manual and power tools in the performance of duties
- (19) Relying on senses of sight, hearing, smell, and touch to help determine the nature of the emergency, to maintain personal safety, and to make critical decisions in a confused, chaotic, and potentially life-threatening environment throughout the duration of the operation

# Medical History and Examination Form for Firefighters

## Medical Standards

*This standard shall contain medical requirements for members, including full-time or part-time employees and paid or unpaid volunteers. It also shall provide information for physicians regarding other areas of fire department medicine, including infection control and fireground rehabilitation.*

*The purpose of this standard shall be to specify minimum medical requirements for candidates and current members. It also shall provide other information regarding fire department activities that assist the department physician in providing proper medical support for members.*

<p><b>Category A Medical Condition</b></p> <p>A medical condition that would preclude a person from performing as a member in a training or emergency operational environment by presenting a significant risk to the safety and health of the person or others.</p>	<p><b>Category B Medical Condition</b></p> <p>A medical condition that, based on its severity or degree, could preclude a person from performing as a member in a training or emergency operational environment by presenting a significant risk to the safety and health of the person or others.</p>
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<b>Head</b>	
<p><b>Category A Medical Condition</b></p> <p>There shall be no Category A medical conditions.</p>	<p><b>Category B Medical Condition</b></p> <ol style="list-style-type: none"> <li>(1) Deformities of the skull such as depressions or exostoses</li> <li>(2) Deformities of the skull associated with evidence of disease of the brain, spinal cord, or peripheral nerves</li> <li>(3) Loss or congenital absence of the bony substance of the skull</li> <li>(4) Any other head condition that results in a person not being able to perform as a member</li> </ol>

<b>Neck</b>	
<p><b>Category A Medical Condition</b></p> <p>There shall be no Category A medical conditions.</p>	<p><b>Category B Medical Condition</b></p> <ol style="list-style-type: none"> <li>(1) Thoracic outlet syndrome</li> <li>(2) Congenital cysts, chronic draining fistulas, or similar lesions</li> <li>(3) Contraction of neck muscles</li> <li>(4) Any other neck condition that results in a person not being able to perform as a member</li> </ol>

<b>Eyes and Vision</b>	
<p><b>Category A Medical Condition</b></p> <ol style="list-style-type: none"> <li>(a) Far visual acuity. Far visual acuity shall be at least 20/30 binocular, corrected with contact lenses or spectacles. Far visual acuity uncorrected shall be at least 20/100 binocular for wearers of hard contacts or spectacles.</li> <li>(b) Peripheral vision. Visual field performance without correction shall be 140 degrees in the horizontal meridian in each eye.</li> </ol>	<p><b>Category B Medical Condition</b></p> <ol style="list-style-type: none"> <li>(1) Diseases of the eye such as retinal detachment, progressive retinopathy, or optic neuritis</li> <li>(2) Ophthalmological procedures such as radial keratotomy or repair of retinal detachment</li> <li>(3) Any other eye condition that results in a person not being able to perform as a member</li> </ol>

## Medical History and Examination Form for Firefighters

### Ears and Hearing

#### Category A Medical Condition

There shall be no Category A medical conditions.

#### Category B Medical Condition

- a) Hearing deficit in the pure tone thresholds in the unaided worst ear that is
- (1) Greater than 25 dB in three of the four frequencies
    - a. 500 Hz
    - b. 1000 Hz
    - c. 2000 Hz
    - d. 3000 Hz

OR
  - (2) Greater than 30 dB in any one of the three frequencies
    - a. 500 Hz
    - b. 1000 Hz
    - c. 2000 Hz

AND
  - (3) In addition averages greater than 30 dB for the four frequencies
    - a. 500 Hz
    - b. 1000 Hz
    - c. 2000 Hz
    - d. 3000 Hz
- (b) Unequal hearing loss
  - (c) Atresia, severe stenosis, or tumor of the auditory canal
  - (d) Severe external otitis
  - (e) Severe agenesia or traumatic deformity of the auricle
  - (f) Severe mastoiditis or surgical deformity of the mastoid
  - (g) Meniere's syndrome or labyrinthitis
  - (h) Otitis media
  - (i) Any other ear condition that results in a person not being able to perform as a member and results in a person being unable to pass a job-specific functional hearing task test or a hearing in noise test

### Dental

#### Category A Medical Condition

There shall be no Category A medical conditions.

#### Category B Medical Condition

- 1) Diseases of the jaws or associated tissues
- (2) Orthodontic appliances
- (3) Oral tissues, extensive loss
- (4) Relationship between the mandible and maxilla that precludes satisfactory postorthodontic replacement or ability to use protective equipment
- (5) Any other dental condition that results in a person not being able to perform as a member

## Medical History and Examination Form for Firefighters

### Nose, Oropharynx, Trachea, Esophagus, and Larynx

Category A Medical Condition	Category B Medical Condition
<ul style="list-style-type: none"> <li>(1) Tracheostomy</li> <li>(2) Aphonia</li> </ul>	<ul style="list-style-type: none"> <li>(1) Congenital or acquired deformity</li> <li>(2) Allergic respiratory disorder</li> <li>(3) Sinusitis, recurrent</li> <li>(4) Dysphonia</li> <li>(5) Anosmia</li> <li>(6) Any other nose, oropharynx, trachea, esophagus, or larynx condition that results in a person not being able to perform as a member or to communicate effectively</li> </ul>

### Lungs and Chest Wall

Category A Medical Condition	Category B Medical Condition
<ul style="list-style-type: none"> <li>(1) Active hemoptysis</li> <li>(2) Empyema</li> <li>(3) Pulmonary hypertension</li> <li>(4) Active tuberculosis</li> </ul>	<ul style="list-style-type: none"> <li>(1) Pulmonary resectional surgery, chest wall surgery, pneumothorax</li> <li>(2) Bronchial asthma or reactive airways disease</li> <li>(3) Fibrothorax, chest wall deformity, diaphragm abnormalities</li> <li>(4) Chronic obstructive airways disease</li> <li>(5) Hypoxemic disorders</li> <li>(6) Interstitial lung diseases</li> <li>(7) Pulmonary vascular diseases, pulmonary embolism</li> <li>(8) Bronchiectasis</li> <li>(9) Infectious diseases of the lung or pleural space</li> <li>(10) Any other pulmonary condition that results in a person not being able to perform as a member</li> </ul>

### Heart

Category A Medical Condition	Category B Medical Condition
<ul style="list-style-type: none"> <li>(1) Angina pectoris, current</li> <li>(2) Heart failure, current</li> <li>(3) Acute pericarditis, endocarditis, or myocarditis</li> <li>(4) Syncope, recurrent</li> <li>(5) Automatic implantable cardiac defibrillator</li> </ul>	<ul style="list-style-type: none"> <li>(1) Significant valvular lesions of the heart, including prosthetic valves</li> <li>(2) Coronary artery disease, including history of myocardial infarction, coronary artery bypass surgery, or coronary angioplasty, and similar procedures</li> <li>(3) Atrial tachycardia, flutter, or fibrillation</li> <li>(4) Left bundle branch block, second- and third-degree atrioventricular block</li> <li>(5) Ventricular tachycardia</li> <li>(6) Hypertrophy of the heart</li> <li>(7) Recurrent paroxysmal tachycardia</li> <li>(8) History of a congenital abnormality</li> <li>(9) Chronic pericarditis, endocarditis, or myocarditis</li> <li>(10) Cardiac pacemaker</li> <li>(11) Coronary artery vasospasm</li> <li>(12) Any other cardiac condition that results in a person not being able to perform as a member</li> </ul>

## Medical History and Examination Form for Firefighters

### Vascular System

#### Category A Medical Condition

There shall be no Category A medical conditions.

#### Category B Medical Condition

- (1) Hypertension
- (2) Peripheral vascular disease such as Raynaud's phenomenon
- (3) Recurrent thrombophlebitis
- (4) Chronic lymphedema due to lymphadenopathy or severe venous valvular incompetency
- (5) Congenital or acquired lesions of the aorta or major vessels
- (6) Marked circulatory instability as indicated by orthostatic hypotension, persistent tachycardia, and severe peripheral vasomotor disturbances
- (7) Aneurysm of the heart or major vessel
- (8) Any other vascular condition that results in a person not being able to perform as member

### Abdominal Organs and Gastrointestinal System

#### Category A Medical Condition

There shall be no Category A medical conditions.

#### Category B Medical Condition

- (1) Cholecystitis
- (2) Gastritis
- (3) GI bleeding
- (4) Acute hepatitis
- (5) Hernia
- (6) Inflammatory bowel disease
- (7) Intestinal obstruction
- (8) Pancreatitis
- (9) Resection, bowel
- (10) Ulcer, gastrointestinal
- (11) Cirrhosis, hepatic or biliary
- (12) Chronic active hepatitis
- (13) Any other gastrointestinal condition that results in a person not being able to perform the duties of member

### Reproductive

#### Category A Medical Condition

There shall be no Category A medical conditions.

#### Category B Medical Condition

- (1) Pregnancy, for its duration
- (2) Dysmenorrhea
- (3) Endometriosis, ovarian cysts, or other gynecologic conditions
- (4) Testicular or epididymal mass
- (5) Any other genital condition that results in a person not being able to perform as a member

## Medical History and Examination Form for Firefighters

### Urinary System

Category A Medical Condition	Category B Medical Condition
There shall be no Category A medical conditions.	(1) Diseases of the kidney (2) Diseases of the ureter, bladder, or prostate (3) Any other urinary condition that results in a person not being able to perform as a member

### Spine, Scapulae, Ribs, and Sacroiliac Joints

Category A Medical Condition	Category B Medical Condition
There shall be no Category A medical conditions.	(1) Arthritis (2) Structural abnormality, fracture, or dislocation (3) Nucleus pulposus, herniation of, or history of laminectomy, discectomy or fusion (4) Ankylosing spondylitis (5) Any other spinal condition that results in a person not being able to perform as a member

### Extremities

Category A Medical Condition	Category B Medical Condition
There shall be no Category A medical conditions.	(1) Limitation of motion of a joint (2) Amputation or deformity of a joint or limb (3) Dislocation of a joint (4) Joint reconstruction, ligamentous instability, or joint replacement (5) Chronic osteoarthritis or traumatic arthritis (6) Inflammatory arthritis (7) Any other extremity condition that results in a person not being able to perform as a member

### Neurological Disorders

Category A Medical Condition	Category B Medical Condition
(1) Ataxias of heredo-degenerative type (2) Cerebral arteriosclerosis as evidenced by documented episodes of neurological impairment (3) Multiple sclerosis with activity or evidence of progression within previous three years (4) Progressive muscular dystrophy or atrophy (5) All epileptic conditions to include simple partial, complex partial, generalized, and psychomotor seizure disorders other than those with complete control during previous five years, normal neurological examination, and definitive statement from qualified neurological specialist.  If an epileptic member experiences a five-year seizure-free interval resulting from a change in the medical regimen, that individual shall not be cleared for return to firefighting duty until he or she has completed five years without a seizure on the new regimen.	(1) Congenital malformations (2) Migraine (3) Clinical disorders with paresis, paralysis, dyscoordination, deformity, abnormal motor activity, abnormality of sensation, or complaint of pain (4) Subarachnoid or intracerebral hemorrhage (5) Abnormalities from recent head injury such as severe cerebral contusion or concussion (6) Any other neurological condition that results in a person not being able to perform as a member

## Medical History and Examination Form for Firefighters

### Skin

#### Category A Medical Condition

There shall be no Category A medical conditions.

#### Category B Medical Condition

- (1) Acne or inflammatory skin disease
- (2) Eczema
- (3) Any other dermatologic condition that results in the person not being able to perform as a member

### Blood and Blood-Forming Organs

#### Category A Medical Condition

- (1) Hemorrhagic states requiring replacement therapy
- (2) Sickle cell disease (homozygous)

#### Category B Medical Condition

- (1) Anemia
- (2) Leukopenia
- (3) Polycythemia vera
- (4) Splenomegaly
- (5) History of thromboembolic disease
- (6) Any other hematological condition that results in a person not being able to perform as a member

### Endocrine and Metabolic Disorders

#### Category A Medical Condition

*Diabetes mellitus, which is treated with insulin or an oral hypoglycemic agent and where an individual has a history of one or more episodes of incapacitating hypoglycemia, shall be a Category A medical condition.*

#### Category B Medical Condition

- (1) Diseases of the adrenal gland, pituitary gland, parathyroid gland, or thyroid gland of clinical significance
- (2) Nutritional deficiency disease or metabolic disorder
- (3) Diabetes mellitus requiring treatment with insulin or oral hypoglycemic agent without a history of incapacitating hypoglycemia
- (4) Any other endocrine or metabolic condition that results in a person not being able to perform as a member

### Systemic Diseases and Miscellaneous Conditions

#### Category A Medical Condition

There shall be no Category A medical conditions.

#### Category B Medical Condition

- (1) Connective tissue disease, such as dermatomyositis, lupus erythematosus, scleroderma, and rheumatoid arthritis
- (2) Residuals from past thermal injury
- (3) Documented evidence of a predisposition to heat stress with recurrent episodes or resulting residual injury
- (4) Any other systemic condition that results in a person not being able to perform as a member

## Medical History and Examination Form for Firefighters

### Tumors and Malignant Diseases

<b>Category A Medical Condition</b>	<b>Category B Medical Condition</b>
There shall be no Category A medical conditions.	(1) Malignant disease that is newly diagnosed, untreated, or currently being treated. <ul style="list-style-type: none"> <li>a. Candidates shall be subject to the provisions of 2-3.5 of this standard.</li> <li>b. Current members shall be subject to the provisions of 2-4.4 of this standard</li> </ul> (2) Treated malignant disease that is evaluated on the basis of an individual's current physical condition and on the likelihood of the disease to recur or progress.                     (3) Any other tumor or similar condition that results in a person not being able to perform as a member

### Psychiatric Conditions

<b>Category A Medical Condition</b>	<b>Category B Medical Condition</b>
There shall be no Category A medical conditions.	(1) A history of psychiatric condition or substance abuse problem (2) Any other psychiatric condition that results in a person not being able to perform as a member

### Chemicals, Drugs, and Medications

<b>Category A Medical Condition</b>	<b>Category B Medical Condition</b>
There shall be no Category A medical conditions.	(1) Anticoagulant agents (2) Cardiovascular agents (3) Narcotics (4) Sedative-hypnotics (5) Stimulants (6) Psychoactive agents (7) Steroids (8) Any other chemical, drug, or medication that results in a person not being able to perform as a member