



Glendale Regional Public Safety Training Center
Annual Patient Health Assessment

Today's Date: ___/___/___

Personal Information:

Legal Name: (Last) (First) (M.I.)
AKA or Nickname:
SSN: - - Date of Birth: / / Sex: M / F
Race: Marital Status:
Address:
City: State: Zip:
Work Phone: Home /Cell Phone:
Best Time To Contact You: AM/PM Email:

Employer Information:

Name of Home Department:
Hire Date: / / Employer Phone:
Rank/Title: Retirement Date: / / (if applicable)
District: Shift: Station: Unit: (ie E, L, R)
Current Assignment: Admin Active Operations Modified / Light Duty

Emergency Notification Information:

In case of emergency, notify:
Relationship: Phone:
Address:
City: State: Zip:

Personal Family Physician Information:

Personal Physician: Phone:
Address:
City: State: Zip:

Education Years: (Check highest level)

High School AA BA/BS MA/MS Other (Specify):

Past Medical Problems/Hospitalizations:

Since your last exam here, have you been hospitalized? Yes No
If yes, please provide details:
Date(s): Reason:

Since your last annual exam, have you had surgery(s)? Yes No
If yes, please provide dates and reasons for surgery:
Date(s): Reason:



PRIVACY PRACTICE – RELEASE OF PERSONAL HEALTH INFORMATION

I acknowledge that I have received a copy of the STI Notice of Privacy Practices / HIPPA.

I give permission to STI to communicate messages regarding APPOINTMENTS as follows:

_____ you may leave a message on my answering machine.

_____ You may leave a message with _____

For REFERRALS to another physician:

_____ You may leave a message on my answering machine.

_____ You may leave a message with _____

For LAB RESULTS, X-RAYS AND OTHER TESTS:

_____ You may leave a message on my answering machine.

_____ You may leave a message with _____

_____ You may email to _____ upon my request.

Patient/Responsible Party Signature

Date

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to STI for medical and/or dental benefits, if any, otherwise paid to me for unpaid services rendered and the release of any information necessary to process claims for said services and authorization to release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical and/or dental charges, including review activities related to my physician's participation with my health plan, via voice, electronic mail or fax transmission. I also agree to pay all charges and/or co-payments at the time of service. In the event of default, I promise to pay all legal fees, collection costs, and/or interest as may be required to effect collection of this note. This will serve as an authorization for release of emergency department, urgent care and/or medical/dental records, which may be necessary in my medical care.

Patient/Responsible Party Signature

Date



New Hire and Annual Firefighter Physical Exam Consent

I understand that I am going to undergo a medical evaluation. This evaluation will assess my physical ability to safely perform my work as a firefighter. The exam is comprehensive and will consist of a battery of tests and measures to assess my general fitness, aerobic capacity and cardiovascular function, pulmonary function, vision, hearing and other medical tests. It may also involve immunization administration per guidelines for your position and specific department. It has been explained to me that I have an obligation to help this test to be safe and accurate:

1. I must give an accurate statement of my past and present physical abilities and medical history.
2. I must provide an accurate account of any exposures I may have been subjected to.
3. I understand that some of these tests require significant physical exertion and could pose risks to my health.
4. I will tell the examiner how I feel during the evaluation.
5. I may stop any test activity at any point if I feel unwilling or unable to progress safely.
6. I understand that I may undergo stress treadmill testing. This testing requires significant physical exertion and could pose a risk to my health.
7. I understand my Heart rate or other vital measures taken during exam should not be perceived as good or bad. While it is recognized that you may experience some fatigue, you should notify the test administrator if you feel any pain or undue fatigue. Together you and the test administrator can decide if the test should continue.

I further understand that this is a professional health care evaluation and that all evaluators are responsible for objective, non-biased accurate reporting and will do so in my report. I understand the test is voluntary and I now agree to proceed with the testing.

Participant Signature

Date

Staff Examiner Signature

Date

Medical History – to be completed prior to exam

Below is a list of health problems. Please report if and how recently you were diagnosed, and whether you are currently experiencing the problem.

Health Problem <small>Diagnosed by a qualified healthcare provider</small>	Diseases	Currently Experience This	Currently Taking Meds	Medications & (Dosages)
Diabetes: Type: I II	<input type="checkbox"/> No <input type="checkbox"/> Yes Yr _____ ⇨	<input type="checkbox"/> Yes ⇨	<input type="checkbox"/> Yes ⇨	1. _____ (_____) 2. _____ (_____)
Hypertension (high blood pressure)	<input type="checkbox"/> No <input type="checkbox"/> Yes Yr _____ ⇨	<input type="checkbox"/> Yes ⇨	<input type="checkbox"/> Yes ⇨	1. _____ (_____) 2. _____ (_____)
Hyperlipidemia (high cholestral / tryglcerides)	<input type="checkbox"/> No <input type="checkbox"/> Yes Yr _____ ⇨	<input type="checkbox"/> Yes ⇨	<input type="checkbox"/> Yes ⇨	1. _____ (_____) 2. _____ (_____)
Cancer: Type: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Yr _____ ⇨	<input type="checkbox"/> Yes ⇨	<input type="checkbox"/> Yes ⇨	1. _____ (_____) 2. _____ (_____)
Heart or Cardiovascular Disease: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Yr _____ ⇨	<input type="checkbox"/> Yes ⇨	<input type="checkbox"/> Yes ⇨	1. _____ (_____) 2. _____ (_____)
Respiratory Disease (asthma, COPD, emphysema, etc)	<input type="checkbox"/> No <input type="checkbox"/> Yes Yr _____ ⇨	<input type="checkbox"/> Yes ⇨	<input type="checkbox"/> Yes ⇨	1. _____ (_____) 2. _____ (_____)
Neurologic Disease (Stroke, TIA, headache, Seizure, etc)	<input type="checkbox"/> No <input type="checkbox"/> Yes Yr _____ ⇨	<input type="checkbox"/> Yes ⇨	<input type="checkbox"/> Yes ⇨	1. _____ (_____) 2. _____ (_____)
Gastrointestinal Disease (ulcer, acid reflux, colitis, etc)	<input type="checkbox"/> No <input type="checkbox"/> Yes Yr _____ ⇨	<input type="checkbox"/> Yes ⇨	<input type="checkbox"/> Yes ⇨	1. _____ (_____) 2. _____ (_____)
Hepatitis: Type: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Yr _____ ⇨	<input type="checkbox"/> Yes ⇨	<input type="checkbox"/> Yes ⇨	1. _____ (_____) 2. _____ (_____)
Allergies:	<input type="checkbox"/> No <input type="checkbox"/> Yes Yr _____ ⇨	<input type="checkbox"/> Yes ⇨	<input type="checkbox"/> Yes ⇨	1. _____ (_____) 2. _____ (_____)
Psychiatric/Psychological (depression, anxiety, PTSD, bipolar, etc)	<input type="checkbox"/> No <input type="checkbox"/> Yes Yr _____ ⇨	<input type="checkbox"/> Yes ⇨	<input type="checkbox"/> Yes ⇨	1. _____ (_____) 2. _____ (_____)
Arthritis: Type: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Yr _____ ⇨	<input type="checkbox"/> Yes ⇨	<input type="checkbox"/> Yes ⇨	1. _____ (_____) 2. _____ (_____)
Orthopedic/Musculoskeletal Body Part (circle all appropriate): Low Back, Shoulder, Knee, Neck,	<input type="checkbox"/> No <input type="checkbox"/> Yes Yr _____ ⇨	<input type="checkbox"/> Yes ⇨	<input type="checkbox"/> Yes ⇨	1. _____ (_____) 2. _____ (_____)
Other Medical Condition _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Yr _____ ⇨	<input type="checkbox"/> Yes ⇨	<input type="checkbox"/> Yes ⇨	1. _____ (_____) 2. _____ (_____)

Additional Information / Comments or Medications: _____

Reviewed with patient by: _____ Date: _____

Have you ever had any of the following?

Yes No

- Heart Attack or Angina
- Any other Heart or cardiac problem that you have not told us about
- Stroke, Trans Ischemic Attack
- Pain or tightness in your chest with physical exertion
- Swelling in legs or feet not caused by walking
- Allergic reactions that interfere with your breathing
- Claustrophobia
- Trouble smelling odors
- Drug or alcohol abuse
- Sleep apnea or difficulty sleeping

Females Only:

- Is there a possibility you could be pregnant?

Since your last Annual Physical, have you developed any new medical problems (not listed above)?

- Yes No If yes, provide details and dates: _____

In the past year have you been on light or modified duty prior to returning to full duty?

- No Yes _____ Days Out Reason: _____

Family History:

1. Do you have a male or female parent, sibling or offspring who was diagnosed with a heart attack, angina, coronary heart disease, stroke or other cardiovascular disease at an age younger than 55 years old?

- Yes No If yes, family member: _____ Age @ Diagnosis: _____ Still Living: Yes No

2. Do you have a male or female parent, sibling or offspring who was diagnosed with cancer?

- Yes No If yes, cancer type (if known): _____
- family member: _____, Age @ Diagnosis: _____ Still Living: Yes No

3. Do you have a grandparent, parent, sibling, or offspring diagnosed with any type of diabetes?

- Yes No If yes, family member: _____ Age @ Diagnosis: _____ Still Living: Yes No

Habits / Lifestyle:

Yes No

- Do you drink alcoholic beverages? If yes, answer the following: (One drink + 1 bottle of beer, 1 glass of wine, or 1 drink of liquor. How many drinks do you drink each week? _____)

- Do you smoke or use tobacco?

If yes, how many do you smoke/chew? Cigarettes/d _____ Cigars/d _____ Cans/w _____ Pipes/d _____

- If no, are you a former smoker or tobacco user ?

If yes, how long ago did you quit? _____ How long did you use tobacco before you quit? _____

How many do you smoke/chew? Cigarettes _____ Cigars _____ Cans/chew _____ Pipes _____

- Do you drink caffeine? If yes, describe how much per day. Include any caffeine related drink (coffee, tea, energy drinks Coke/Pepsi). Which kind and how much? _____

Fitness Review:

Please list your exercise activities and number of times per week you perform each.

Aerobic Exercise: _____ X per week in the past month

Reviewed with patient by: _____ Date: _____

Walking: _____ X per week in the past month
Strength / Weight Training: _____ X per week in the past month

Other Exercise: _____

Since your last exam, compare your activity level: More Less Same

Cumulative EMS/Fire Experience:

Indicate the # of years in each position(s):

Firefighter _____ Engineer _____ Captain _____ BC _____ Admin _____

Occupational Exposures:

Are you a member of a Special Team Yes No

If yes, what type: Hazmat or tech Technical Rescue Scuba/Dive Other _____

Have you had any work related exposures to fires or HAZMAT situations where you have developed health changes or have concerns about your health? Yes No

If yes, provide details: _____

Yes No

Do you have any second jobs or side businesses? If yes, what is it? _____

Do you have a prior occupation? If yes, please list. _____

Have you been in the military services:

If yes, were you exposed to biologic or chemical agents (in either training or combat)

If yes, please identify the agent. _____

Have you ever worked on a HAZMAT Team?

Do you use firearms for hunting, or recreation?

Do you have exposure to racing cars, ATVs, Motorcycles, 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? _____

Do you use any chemicals/ materials in your hobbies(eg solvents, solder, pesticides, lead or other metals,

If yes, provide details _____

Reproductive Health:

Have you had any difficulties having children (e.g. Infertility, Miscarriage)?

Yes No

If yes, provide details: _____

Preventative Screening Tests Performed Outside of Your Annual Physical in the past year:

PSA (prostate test): No Yes Normal Abnormal

Testicular: No Yes Normal Abnormal

DRE: No Yes Normal Abnormal

(digital rectal exam)

Reviewed with patient by: _____ Date: _____

Colonoscopy: No Yes Normal Abnormal
(strongly advised for FF over 40)

Skin: No Yes Normal Abnormal

Cardiac Stress Test: No Yes Normal Abnormal

Females Only

Pap Smear: No Yes Normal Abnormal

Mammogram: No Yes Normal Abnormal

Immunization History:

Have you ever had a tetanus shot? Yes No
 If so when? _____
If yes, have you had a tetanus booster?

Have you been vaccinated for mumps,
measles and rubella (MMR)?

Varicella (chickenpox)

Influenza

Hepatitis A

Hepatitis B

Other (explain):

Is there any additional information you would like to convey or discuss during this visit?

