WOLFFORTH FIRE ACADEMY

STUDENT PHYSICAL EVALUATION FORM

PLEASE COMPLETE THE FOLLOWING INFORMATION

NAME: ____

TODAY'S DATE: ________________________

SOCIAL SECURITY NUMER: _______ / ______ / _______ DATE OF BIRTH: ______________________

HOME ADDRESS:____

CELL PHONE: _________________________

PRIMARY PHYSICIAN: ______________________________________ PHYSICIAN PHONE:____________

PRIMARY PHYSICIAN ADDRESS:____

Please turn to the next page to complete your medical history.

Do not write in this box – For Medical Providers Only

□ PFT done	Normal	Abnormal	
□ EKG done	Normal	Abnormal	N/A
□ Audiogram done	Normal	Abnormal	N/A
□ Urine dip done	Normal	Abnormal	
□ Fingerstick Glucose	Normal	Abnormal	
□ Vaccine done	□ Hep B	□ Tetanus	

Comments: ____

____

YES □ NO □ Appropriate for firefighting activities?

If "NO" please explain reason on the backside of this sheet.

Where was this physical performed? ______________________________

Provider Signature: ____ Date: ________________

Print Name: ____

Have you ever had any of the following pulmonary or lung illnesses?

YES □ NO □ Asbestosis

YES □ NO □ Asthma

YES □ NO □ Broken Ribs

YES □ NO □ Chronic bronchitis

YES □ NO □ Emphysema

YES □ NO □ Lung cancer

YES □ NO □ Pneumonia

YES □ NO □ Pneumothorax (collapsed lung)

YES □ NO □ Silicosis

YES □ NO □ Tuberculosis

YES □ NO □ Have you ever had any lung or chest surgeries or injuries?

If "YES", please explain: ____

YES □ NO □ Have you ever had a chest x-ray? Please give the approximate date of your most recent:

Date: _______________ Was it NORMAL ABNORMAL NOT SURE (Please circle one)

Do you currently have any of the following symptoms of pulmonary or lung illness?

YES □ NO □ Shortness of breath

YES □ NO □ Shortness of breath when walking fast on level ground or walking up a slight hill or incline

YES □ NO □ Shortness of breath when walking with other people at an ordinary pace on level ground

YES □ NO □ Have to stop for breath when walking at your pace on level ground

YES □ NO □ Shortness of breath when washing or dressing yourself

YES □ NO □ Shortness of breath that interferes with your job

YES □ NO □ Coughing that produces phlegm (thick sputum)

YES □ NO □ Coughing that wakes you early in the morning

YES □ NO □ Coughing that occurs mostly when you are lying down

YES □ NO □ Coughing up blood in the last month

YES □ NO □ Wheezing

YES □ NO □ Wheezing that interferes with your job

YES □ NO □ Chest pain when you breathe deeply

YES □ NO □ Allergic reactions that interfere with your breathing

YES □ NO □ Do you have any other lung problems that you have been told about?

If "YES", please explain: ____

YES □ NO □ Has your doctor recommended that you **currently** limit any of your work, recreation or hobby activities due to any of the lung problems listed above?

If "YES", please explain: ____

CARDIOVASCULAR

Have you ever had any of the following cardiovascular or heart problems?

YES □ NO □ Angina

YES □ NO □ Coronary artery bypass surgery or an angioplasty/balloon catheterization YEAR______________

YES □ NO □ Heart arrhythmia (irregular heartbeat)

YES □ NO □ Heart attack (MI)

YES □ NO □ Heart failure

YES □ NO □ Heart murmur

YES □ NO □ High blood pressure

YES □ NO □ Swelling in your legs or feet (not caused by walking)

Have you ever had any of the following cardiovascular or heart symptoms?

YES □ NO □ Frequent pain or tightness in your chest at rest

YES □ NO □ Pain or tightness in your chest during physical activity

YES □ NO □ In the past two years, have you noticed your heart skipping or missing a beat

YES □ NO □ Heartburn or indigestion that is related to physical activity

YES □ NO □ Any other symptoms that you think may be related to heart or circulation problems:

Please explain: ____

YES □ NO □ Have you ever had an EKG (electrocardiogram)? Please give the approximate date of your most recent EKG: ___________________________________

Was it NORMAL ABNORMAL DON'T KNOW (Please circle one)

YES □ NO □ Have you ever had a Stress Test or treadmill EKG (electrocardiogram)? Please give the approximate date of your most recent stress test: ______________

Was it NORMAL ABNORMAL DON'T KNOW (Please circle one)

YES □ NO □ Has your doctor recommended that you **currently** limit any of your work, recreation or hobby activities due to any of the heart problems listed above?

If "YES", please explain: ____

NEUROLOGIC

Have you ever had any of the following neurologic conditions?

YES □ NO □ Frequent headaches

YES □ NO □ Multiple sclerosis

YES □ NO □ Paralysis/Spinal cord injury

YES □ NO □ Seizures/Epilepsy (fits)

YES □ NO □ Stroke/Cerebral Vascular Accident

YES □ NO □ Any other neurological illness or injury? Please explain: ____

YES □ NO □ Has your doctor recommended that you **currently** limit any of your work, recreation or hobby activities due to any of the neurological problems?

If "YES", please explain: ____

GASTROINTESTINAL/KIDNEY

Have you ever had any of the following INTESTINAL/STOMACH/KIDNEY conditions?

YES □ NO □ Appendicitis

YES □ NO □ Gallbladder

YES □ NO □ Hiatal hernia

YES □ NO □ Liver Disease (Cirrhosis, Hepatitis)

YES □ NO □ Reflux (GERD)

YES □ NO □ Ulcers

YES □ NO □ Any other intestinal or kidney illness or injury? Please explain: ___________________________________

YES □ NO □ Has your doctor recommended that you **currently** limit any of your work, recreation or hobby activities due to any of the intestinal or kidney problems listed?

If "YES", please explain: ____

EYES

Do you currently have any of the following vision problems?

YES □ NO □ Cataracts

YES □ NO □ Color blind

YES □ NO □ Glaucoma

YES □ NO □ Lost vision in either eye (temporarily or permanently)?

YES □ NO □ Wear contact lenses or wear glasses

YES □ NO □ Any other eye or vision problem? Please explain: ____

EARS

Do you currently have any of the following hearing problems?

YES □ NO □ Broken ear drum

YES □ NO □ Difficulty hearing __________ Left ear AND/OR __________ Right ear

YES □ NO □ Ringing in the ears

YES □ NO □ Wear a hearing aid

YES □ NO □ Any other hearing or ear problems? Please explain: ____

MUSCULOSKELETAL

Do you currently have any of the following musculoskeletal problems?

YES □ NO □ Arthritis

YES □ NO □ Back pain, including sciatica, herniated or bulging disk, arthritis, or muscle strain

YES □ NO □ Difficulty climbing a flight of stairs or ladder carrying more than 25 pounds

YES □ NO □ Difficulty or weakness fully moving your arms and legs

YES □ NO □ Difficulty fully moving your head in any direction

YES □ NO □ Difficulty bending at your knees

YES □ NO □ Difficulty squatting to the ground

YES □ NO □ Gout

YES □ NO □ Pain or stiffness when you lean forward or backward at the waist

YES □ NO □ Any other muscle or skeletal problems that interferes with performing work activities including using a respirator? Please explain: ____

YES □ NO □ Has your doctor recommended that you **currently** limit any of your work, recreation or hobby activities due to any of the musculoskeletal problems listed?

If "YES", please explain: ____

GENERAL MEDICAL

Do you have any of the following:

YES □ NO □ Anemia

YES □ NO □ Cancer

YES □ NO □ Claustrophobia (fear of closed-in places)

YES □ NO □ Diabetes (sugar disease)

YES □ NO □ Thyroid disease

YES □ NO □ Trouble smelling odors

TOBACCO & ALCOHOL

YES □ NO □ Do you currently smoke tobacco / vape?

YES □ NO □ Have you in the past smoked tobacco / vaped?

If you have smoked / vaped or do smoke / vape, how many years have you smoked / vaped? _________

How many packs per day have/do you smoke? __________ How often per day do you vape? _________

YES □ NO □ Do you drink alcohol?

On the average, how much of the following do you drink per week?

Beer: _____ cans/bottles Wine: _____ glasses Whiskey/liquor: ______ jiggers/shots

FAMILY MEDICAL HISTORY

If a family member has had any of the following medical conditions, please write the number which corresponds to that family member in the space provided.

1. Father   2. Mother   3. Grandparent   4. Brother/Sister   5. Children

_______ Cancer   _______ Liver Disease/Cirrhosis   _______ Diabetes   _______ Seizure/Epilepsy

_______ Hypertension   _______ Heart Disease   _______ Lung Disease

YES □ NO □ Is your father still living? If "NO", what age did he die? _________________

What was the cause of death? ____

YES □ NO □ Is your mother still living? If "NO", what age did she die? _________________

What was the cause of death? ____

RESPIRATORY PROTECTION

You will use the following respirators in the academy:

A. N, R, or P disposable respirator (filter-mask, non-cartridge type only)
B. Other type (for example: half-or full-face piece type, powered-air purifying, supplied-air, **self-contained breathing apparatus**)

YES □ NO □ Have you worn a respirator? If "YES", please circle what type(s):

Disposable/paper mask   Filter/cartridge style or half or full-face piece mask

Military gas mask   **Self-Contained Breathing Apparatus (SCBA)**

Supplied-Air or Type C respirator

If you have **used a respirator**, have you ever had any of the following problems related to using a respirator?

YES □ NO □ Anxiety

YES □ NO □ Eye irritation/Difficulty seeing in your mask

YES □ NO □ Shortness of breath

YES □ NO □ Skin allergies or rashes

YES □ NO □ Any other problems that interferes with your use of a respirator?

Please explain: ____

PROTECTIVE EQUIPMENT

YES □ NO □ Do you have any latex or rubber sensitivity?

YES □ NO □ Do you get rashes after wearing protective clothes?

YES □ NO □ Do you become overheated wearing protective clothes?

HEALTH STATUS

Please indicate what you believe your health status is today: ______ Excellent ______ Good ______ Fair ______ Poor

YES □ NO □ Have you been examined or treated by a health care provider within the last 12 months for?

Injury (please explain) ____

Illness (please explain) ____

Routine physical or follow-up (please explain) ____

SURGICAL HISTORY

Please list any surgical procedures you have had, and if possible, list dates (or approximate) dates:

surgical procedure	date
______________________	____________
______________________	____________
______________________	____________
______________________	____________
______________________	____________
______________________	____________

MEDICATION LIST

Please list any medications that you are currently taking:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

I have answered this health questionnaire completely and honestly and understand I can review any questions with my examiner if I am unsure or need to further explain.

Student Signature: ____________________________________ Date: ________________

AUDIOMETRIC EVALUATION

Name: ____ SSN: ______________________________

DOB: __________________ Age: ____________ Date: ________

Occupation: Fire Academy

PLEASE CIRCLE ANSWERS TO QUESTIONS 1 – 11:

1. Have you had any loud noise exposure in the past 14 hours (prior to test)?..............................YES NO
2. Are you experiencing a ringing, buzzing, or plugging sensation in either ear today?..................YES NO
3. Do you ever have ringing in your ears?...YES NO
4. Do you have a "head cold" or congestion today?..YES NO
5. Have you ever been exposed to loud noise from military activities?...............................YES NO

   If "YES", please explain the type of noise: ______________________________________

   Length of time (years) of exposure __________ years
6. Have you ever worked on a noisy job?..YES NO

   If "YES", please explain: ____

   Length of time (years) of exposure __________ years
7. Have you had regular exposure to any of the following non-occupational noise sources:

   Power or Air Tools _______ Target shooting or hunting _______ Chain Saws _______

   Motorcycles/snowmobiles _______ Loud Music _______ Other __________________
8. Have you ever been found to have a hearing loss?..YES NO

   If "YES", please explain: ____
9. Does anyone in your family have a hearing loss?...YES NO
10. Do you wear a hearing aid?...YES NO
11. Have you ever had any of the following?

Ear Infections	YES	NO	Diabetes	YES	NO
Ear injury	YES	NO	Head injury	YES	NO
Ear surgery	YES	NO	Mumps/Measles/Scarlet Fever	YES	NO
Stroke	YES	NO			

Student Signature: ____ Date: ___________________

PHYSICAL EVALUATION

Name: ____

Date of Exam: ____________________________ DOB: ________________________

Blood Pressure _________ / _________ Pulse _________ (regular / irregular)

Height _________ (in) Weight _________ (lbs)

Fingerstick Glucose: Normal / Abnormal

Urine dip: Normal / Abnormal (presence of glucose, protein and/or blood)

VISION Corrective lenses? Yes or No

VISION	OD (Right)	OS (Left)	OU (Both)
DISTANCE	20 /	20 /	20 /
NEAR	20 /	20 /	20 /
COLOR	Normal / Abnormal	Normal / Abnormal	
PERIPHERAL			

HEARING Perceives whisper at five (5) feet? AS Yes or No AD Yes or No

PHYSICAL EXAM

	Normal	Abnormal	Comments
1. Head and neck			
2. Eyes and vision			
3. Ears and hearing			
4. Dental			
5. Nose, Oropharynx, Trachea, Esophagus, and Larynx			
6. Lungs and Chest Wall			
7. Heart and Vascular System			
8. Abdominal Organ and Gastrointestinal System			
9. Reproductive System			
10. Urinary System			
11. Spine and Axial Skeleton			
12. Extremities			
13. Neurological Disorders			
14. Skin			
15. Blood and Blood-Forming Organs			
16. Endocrine and Metabolic Disorders			
17. Systemic Diseases and Miscellaneous Conditions			
18. Tumors and Malignant Diseases			
19. Psychiatric Conditions			
20. Chemicals, Drugs, and Medications			

I certify that I have reviewed the examination form and performed a physical examination on this patient.

Examiner's Signature: ____ Date: ____________________

Title of Examiner: ____

A referral has been made for further evaluation to: ____

Comments: ____