GRIFFIN HEALTH
OCCUPATIONAL MEDICINE
& REHABILITATION SERVICES

FIREFIGHTER Medical Record

Name:		Date:	
Address:	City, State, Zip:		
Phone: Home:	Cell:	Work:	Sex: ☐F ☐M
Email Address:		DOB:	
Primary Care Provider:	Town of Primary Care Provider:		
Date of Last Physical with your Primary Care Provider:			
Family History: (Check) ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Stroke			
Dominate Hand: (Check) ☐ Left ☐ Right			

List Any Hospitalizations or surgery you have had in the past

Date	Reason

Are you currently taking any Medication including prescriptions, vitamins, and supplements? ☐ **Yes** ☐ **No**
If yes, what are they:

_____

Do you smoke tobacco? ☐ **Yes** ☐ **No** If yes, # of packs per day _____ / Years _____
If you smoked in the past, when did you quit? _____

Are you using harmful drugs? ☐ **Yes** ☐ **No**

How much alcohol do you drink? ☐ None ☐ 1-7 drinks per week ☐ 8-14 drinks per week ☐ 15+ drinks per week

How many days of work did you miss in the past 12 months due to illness or injury? _____

Have you been in the military service? ☐ Yes ☐ No Branch of service: _____

How long? _____ Assignment: _____

List any health issues you have:
Do you have any allergies to medication, food or chemical? If so, please describe reaction:

Firefighter duties applied for: Interior, Exterior, Fire-Police?
What do you do for work?

Patient Name: _____ DOB: _____

Please check if you have or have had any in the past:

	Weight loss > 10lbs w/o diet		Breast lumps		Frequent diarrhea		Head injury
	Recent weight gain of > 10lbs		Breast surgery		Hepatitis or jaundice		Concussion
	Change in appetite		Frequent coughs		Hernia		Loss of consciousness
	Persistent fatigue		Bronchitis		Kidney infection		Memory loss
	Night sweats		Emphysema		Bladder infection		Sleep disturbance
	Skin rash		Asthma or wheezing		Kidney stones		Nervousness
	Glaucoma/cataracts		Pneumonia		Painful urination		Mental illness
	Wear glasses or contacts		Coughed up blood		Bloody urine		Fear of heights
	Blurred vision / double vision		High blood pressure		Urinating frequently night		Diabetes
	Eyes sensitive to light		Shortness of breath		Discharge from penis		Thyroid problems
	Sinus pain		Sleep on 2 more pillows		Arthritis		Goiter
	Ear surgery		Heart attack		Tendonitis/bursitis		Rheumatic fever
	Ear pain or discharge		Stroke		Swelling of joints		Polio
	Ear infection		Chest pain / angina		Fracture		Tuberculosis
	Frequent/ severe headache		Palpitation / heart flutter		Dislocation of joint		Venereal disease
	Dizziness		Heart murmur		Arm pain		Cancer
	Fainting		Calf pain		Arm/leg weakness		Multiple sclerosis
	Hearing aid		Ankle swelling		Weakness/tingling fingers		Carpal tunnel syndrome
	Change in hearing		Blood clots		Hand surgery		Silicosis
	Anorexia		Repeated infection		Knee injury/surgery		Asbestosis
	Bulimia		Frequent indigestion		Foot problems		Seizures/convulsions
	Recurrent mouth sores		Stomach pain		Muscle spasm		**For Women**
	Bleeding gums		Vomited blood		Back pain/injury		Problems with periods
	Difficulty swallowing		Change in bowl habits		Back surgery		Pregnancies # _____
	Persistent hoarseness		Bloody/black bowl		Tremors		Problems with pregnancy
	Neck injury		Frequent constipation		Anemia		Are you pregnant now
	Neck radiation		Hemorrhoids		Blood transfusion		Last menstrual period Date: _____

Please check if you have ever had the following:

	Been, or now involved in litigation for personal injury		Been made ill by your work
	Been discharged from the military for health reasons		Received workers compensation
	Been rejected from the military for health reasons		Filed workers compensation claim
	Been refused employment for health reasons		Been refused life insurance
	Been forced to give up a job for health reasons		Collected pension for disability
	Moved from your home because of health risks		Worked with radioactive material

Explain:

Patient Name: _____ DOB: _____

Communicable Disease History:

Please check if you have ever had:	Yes	No
Scarlet Fever	☐	☐
Measles	☐	☐
German Measles	☐	☐
Mumps	☐	☐
Chicken Pox	☐	☐
Hepatitis	☐	☐
Covid-19	☐	☐

Immunization Record:

☐ Vaccinated as a child in the USA

MMR Vaccine _____

Hepatitis B Vaccine _____

Flu Vaccine _____

Varicella Vaccine _____

Tetanus Toxiod _____

COVID-19 Vaccine _____

Medical History:

Please check if you have or have had in the past:	Yes	No
Shortness of Breath at rest or exertion?	☐	☐
Chest Pain at rest or exertion?	☐	☐
Dizziness?	☐	☐
Palpitations or Racy Heart?	☐	☐
Back or Neck Injury or Pain?	☐	☐
Joint or Muscle Injury or Pain?	☐	☐
Do you have any Hernias?	☐	☐
History of Motor Vehicle Accidents?	☐	☐
History of any Sport Injuries?	☐	☐

The statements made on this form are true and complete:

_____ _____

Signature of patient **Date**

Section below to be completed by office:

Explanation of positive answers from page 2 & 3:

Signature of person reviewing form: _____ **Date:** _____

Physical Examination

(To be completed by Medical Provider)

Patient Name: _____ DOB: _____

Height: in	Weight: lbs	BP: /	Temp: °F	HR:
BMI:		Repeat BP: /	RR:	Pulse Ox: %

Vision:	Uncorrected	Corrected	Comments:
Right eye:	20/_____	20/_____	
Left eye:	20/_____	20/_____	
Both eyes:	20/_____	20/_____	
Near Vision	20/_____	20/_____	

Peripheral Vision: Right Eye:_____° Left Eye:_____°

Color Blind Test: Can the firefighter distinguish between Red, Yellow, and Green? ☐ YES ☐ NO

	Normal	Abnormal	Explanation
Head: a. Eyes b. Ears			
Neck: a. Thyroid/ Lymphatics b. ROM c. Scar			
Lungs/Chest:			
Heart:			
Abdomen: a. Masses b. Hernias c. Scars			
Extremities: (Include ROM for knees) a. Reflexes / Strength b. Range of Motion			
Back: a. Movement/ROM b. Posture c. Scars			

Patient Name: _____ DOB: _____

Are there any musculoskeletal problems that would affect the individual's physical capability to do this job?
Check: ☐ **Yes** ☐ **No** **Explain**:

Work Limitations for current position: Explain:

Any additional comments:

Is this person medically qualified for this job placement: Check ☐ **Yes** ☐ **No** **Explain**:

Signature of Medical Provider: _____ **Date:** _____