



Health Center

**Annual Patient Health Review
Cover Sheet**

***Please read the statement below before completing the
attached form.***

The Genetic Information Non-Discrimination Act (GINA)

“The Genetic Information Non-Discrimination Act” of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.”

In addition, you should have also received a copy of the Health Center’s Notice of Privacy Practices.

Please sign below indicating that you have read and understand the information provided regarding the *GINA Act* and have received a copy of our *Notice of Privacy Practices*.

Printed Name: _____

Signature: _____

Date: _____

**Please do not remove cover sheet.
Thank you!**

Phoenix Fire Department Health Center

Annual Patient Health Review

Today's Date: ____/____/____

Personal Information:

Legal Name:

Last: _____ First: _____ M.I. _____

Nickname: _____ Last four digits SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Pager: _____ Cell: _____

D.O.B. ____/____/____ Marital Status: _____

Employer Information:

City of: _____ Hire date: ____/____/____

Employer Phone: _____

Department/Station: _____ Rank/Title: _____

Shift: _____ Employee I.D.#: _____ *(City of Phoenix only)*

Retirement Date: ____/____/____ *(if applicable)*

***** Only complete this section if there have been changes since last exam *****

Emergency Notification Information

In case of emergency notify: _____

Relationship: _____ Phone number: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Care Physician Information:

Primary Care Physician: _____

Physician Office Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Since your last exam, have you had any health issue changes or problems?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

If **yes**, please explain: _____

Since your last exam, have you been **hospitalized**?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

If **yes**, please give dates and details below:

Date(s): _____ Reason: _____

Since your last exam, have you had any **surgery(s)**?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

If **yes**, please give dates and details below:

Date(s): _____ Reason: _____

OSHA Respiratory Questionnaire:

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

	YES	NO
1. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
2. Shortness of breath when walking fast on level ground or walking up a slight incline	<input type="checkbox"/>	<input type="checkbox"/>
3. Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
4. Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
5. Shortness of breath when washing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>
6. Shortness of breath that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
7. Coughing that produces phlegm (thick sputum)	<input type="checkbox"/>	<input type="checkbox"/>
8. Coughing that wakes you early in the morning	<input type="checkbox"/>	<input type="checkbox"/>
9. Coughing that occurs mostly when you are lying down	<input type="checkbox"/>	<input type="checkbox"/>
10. Coughing up blood in the last month	<input type="checkbox"/>	<input type="checkbox"/>
11. Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
12. Wheezing that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
13. Chest pain when you breathe deeply	<input type="checkbox"/>	<input type="checkbox"/>
14. Any other symptoms that you think may be related to lung problems	<input type="checkbox"/>	<input type="checkbox"/>

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

	YES	NO
1. Frequent pain or tightness in your chest	<input type="checkbox"/>	<input type="checkbox"/>
2. Pain or tightness in your chest during physical activity	<input type="checkbox"/>	<input type="checkbox"/>
3. Pain or tightness in your chest that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
4. In the past two years have you noticed your heart skipping/missing a beat	<input type="checkbox"/>	<input type="checkbox"/>
5. Heartburn or indigestion that is not related to eating	<input type="checkbox"/>	<input type="checkbox"/>
6. Any other symptoms you think may be related to heart or circulation problems	<input type="checkbox"/>	<input type="checkbox"/>

If you've used a respirator, have you ever had any of the following problems?

	YES	NO
1. Eye irritation	<input type="checkbox"/>	<input type="checkbox"/>
2. Skin allergies or rashes	<input type="checkbox"/>	<input type="checkbox"/>
3. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
4. General weakness or fatigue	<input type="checkbox"/>	<input type="checkbox"/>
5. Any other problem that interferes with your use of a respirator	<input type="checkbox"/>	<input type="checkbox"/>

Alcohol / Tobacco Use:

How many beers do you drink each week? _____

How many bottles of wine per week? _____

How many drinks of liquor per week? _____

Tobacco Current Use:

Do you currently use tobacco? _____

How many of the following do you smoke or chew per day?

Cigarettes _____ Packs/day x _____ years

Chew _____ Cans/day x _____ years

Tobacco Past Use:

Have you used tobacco in the past? _____

How many of the following do you smoke or chew per day?

Cigarettes _____ Packs/day x _____ years

Chew _____ Cans/day x _____ years

Quit Date _____

Fitness Review:

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

Aerobic _____ x week

Weight Training _____ x week

Other: _____

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

Occupational Exposures:

Have you had any work related exposures to fires or HazMat situations where you have developed health changes?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

If **yes**, please describe: _____

Other Work Related Health Problems (since last exam)

Occupational Injuries/Illnesses: _____

Diagnosis: _____ Time Lost: _____

Are you a member of the **Hazardous Materials Team**?

If **yes**, have you had any exposures in the last year?

Are you a member of the **FEMA (AZ Task Force-1)** team?

If **yes**, have you been on a deployment in the last year?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Recreational / Hobbies Review:

Are you finding your hobbies and recreation less enjoyable?
 Do you feel fatigued even if you have not been physically active?
 Are you worrying more than usual?
 Are you more irritable than usual around family or co-workers?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

List your hobbies (i.e. woodworking, stained glass, etc) and number of times per week you perform them:

1. _____ x week _____
2. _____ x week _____
3. _____ x week _____
4. _____ x week _____

Do you use any chemicals or other materials in your hobbies such as solvents, solder, pesticides, lead, or other materials?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

If **yes**, please describe chemicals involved: _____

Medication Review:

Are you currently taking, or have you taken any of the following within the past month?

<input type="checkbox"/> Antacids	<input type="checkbox"/> Blood pressure pills	<input type="checkbox"/> Sleeping pills
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Codeine	<input type="checkbox"/> Testosterone/Anabolic Steroid
<input type="checkbox"/> Anticoagulants (blood thinners)	<input type="checkbox"/> Cortisone or Steroids	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Antidepressants	<input type="checkbox"/> Digitalis	<input type="checkbox"/> Tranquilizers
<input type="checkbox"/> Antihistamines	<input type="checkbox"/> Diuretic (water pills)	<input type="checkbox"/> Tylenol
<input type="checkbox"/> Anti-inflammatory	<input type="checkbox"/> Hormones	<input type="checkbox"/> Vitamins/Supplements
<input type="checkbox"/> Appetite suppressants	<input type="checkbox"/> Insulin/oral diabetic drug	
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Laxatives	

List any drugs (by name) you take regularly and the dosage used:

Since your last exam, have you developed any allergies?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

If **yes**, please describe _____

Since your last exam, have you had any difficulties having children?
 (i.e. infertility, miscarriage, spontaneous abortion)

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

If **yes**, please describe: _____