

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

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 If **yes**, please give dates and details below:
 Date(s): _____ Reason: _____

Since your last exam, have you had any **surgery(s)**? YES NO

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 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 | | |
| 2. Shortness of breath when walking fast on level ground or walking up a slight incline | | |
| 3. Shortness of breath when walking with other people at an ordinary pace on level ground | | |
| 4. Have to stop for breath when walking at your own pace on level ground | | |
| 5. Shortness of breath when washing or dressing yourself | | |
| 6. Shortness of breath that interferes with your job | | |
| 7. Coughing that produces phlegm (thick sputum) | | |
| 8. Coughing that wakes you early in the morning | | |
| 9. Coughing that occurs mostly when you are lying down | | |
| 10. Coughing up blood in the last month | | |
| 11. Wheezing | | |
| 12. Wheezing that interferes with your job | | |
| 13. Chest pain when you breathe deeply | | |
| 14. Any other symptoms that you think may be related to lung problems | | |

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

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

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

- | | YES | NO |
|--|-----|----|
| 1. Eye irritation | | |
| 2. Skin allergies or rashes | | |
| 3. Anxiety | | |
| 4. General weakness or fatigue | | |
| 5. Any other problem that interferes with your use of a respirator | | |

Family History

Is there any new family history of the following?

Cancer Diabetes Heart Disease High blood pressure Stroke

If so, who? _____

Alcohol / Tobacco Use:

Do you drink alcoholic beverages?

YES	NO

If **yes**, please answer the following questions:

How many beers do you drink each week? _____

How many bottles of wine per week? _____

How many drinks of liquor per week? _____

Do you smoke or chew tobacco?

YES	NO

If **no**, are you a former smoker or chewer?

How long since you quit? _____

How many years did you smoke and/or chew? _____

How much were you using when you quit (i.e. pipes, cigarettes, or cigars smoked per day, or cans of chewing tobacco per week) _____

If **yes**, how long have you smoked or chewed? _____

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

Cigarettes _____ Pipes of tobacco _____

Cigars _____ Cans of chewing tobacco/wk _____

Fitness Review:

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

Aerobic _____ x week

Walking _____ 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

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

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: _____