EAST VALLEY WELLNESS CENTER

P.O. Box 52992 Phone: 480-373-2399
Mesa, AZ 85208 evwellness.com Fax: 480-373-2396

MEDICAL HISTORY QUESTIONNAIRE

TO THE APPLICANT: *Firefighters are required to perform a variety of strenuous and difficult job functions. A medical examination, including this form, is required prior to your scheduled appointment. This is to ensure that you are able to safely perform the essential job functions of a firefighter. Complete and submit this form prior to your scheduled physical examination.*

NAME _____ _____ _____ ***SEX:*** _____
First *Middle* *Last*

HOME ADDRESS: _____ _____ _____ _____
Numbers and Street Name *City* *State* *Zip Code*

DATE OF BIRTH: _____ ***AGE:*** _____ ***CURRENT OCCUPATION:*** _____

HOME PHONE: _____ ***CELL PHONE:*** _____

AGENCY: _____ ***EMPLOYEE #:*** _____

SECTION A. *Have you ever or do you now have any of the following? For "YES" answers, supply full details in Section B of this form. If the condition required hospitalization, list the YEAR in the corresponding box marked under the title "HOSPITAL".*

CONDITION	YES	NO	HOSPITAL
GENERAL:			
Allergies (hayfever), sensitivity to dust	☐	☐	
Sleep problems	☐	☐	
Fatigue	☐	☐	
Stress	☐	☐	
Weight change	☐	☐	
Addiction to drugs or alcohol	☐	☐	
Mononucleosis	☐	☐	
Polio	☐	☐	
Chicken pox (Varicella)	☐	☐	
Hepatitis, jaundice, or liver ailment	☐	☐	
Hepatitis Type:			
Rubella (German/3 Day Measles)	☐	☐	
Rubeola (Hard/2 Week Measles)	☐	☐	
Meningitis	☐	☐	
Valley Fever	☐	☐	
Any complications from childhood diseases	☐	☐	
Any contagious disease	☐	☐	
Any immune system disorder	☐	☐	
Cancer, tumor, growth, or cyst	☐	☐	
X-Ray treatment (Radiation therapy)	☐	☐	
HEAD:			
Severe or frequent headache or migraine	☐	☐	
Severe trauma to head	☐	☐	
Fainting, dizziness, convulsion, or epilepsy	☐	☐	
Concussion or skull fracture	☐	☐	

CONDITION	YES	NO	HOSPITAL
Recent problems with teeth/dentures	☐	☐	
Date of last dental exam:			
Frequent mouth ulcers/infections	☐	☐	
Frequent sore throat or nose bleeds	☐	☐	
Trouble with thyroid	☐	☐	
EYES:			
Glasses or contacts	☐	☐	
Eye injury or surgery	☐	☐	
Glaucoma or cataracts	☐	☐	
Double vision	☐	☐	
Blurred vision	☐	☐	
Eye pain to light	☐	☐	
Excessive tearing	☐	☐	
Yellow color	☐	☐	
Itching or red eyes	☐	☐	
Date of last vision screen:			
EARS:			
Hard of hearing	☐	☐	
Discharge	☐	☐	
Ringing	☐	☐	
Earache	☐	☐	
Meniere's Disease	☐	☐	
Hearing aids	☐	☐	
CONTINUE ON NEXT PAGE			

Print Applicant Name:

SECTION A. Continued			
CONDITION	***YES***	***NO***	***HOSPITAL***
NOSE & SINUS:			
Discharge	☐	☐	
Bleeding	☐	☐	
Obstruction	☐	☐	
Frequent infections	☐	☐	
NECK:			
Pain	☐	☐	
Limited movement	☐	☐	
Lumps	☐	☐	
CARDIOVASCULAR:			
High or low blood pressure	☐	☐	
Angina	☐	☐	
Anemia or any blood disease	☐	☐	
Heart murmur or rheumatic fever	☐	☐	
Heart disease (including circulatory problems)	☐	☐	
High Cholesterol	☐	☐	
Varicose veins, blood clots, phlebitis	☐	☐	
Unusually cold or bluish-colored hands/feet	☐	☐	
Any type of blood disorder	☐	☐	
Pain in chest	☐	☐	
CHEST & BREAST:			
Pain in breast	☐	☐	
Discharge from nipple(s)	☐	☐	
Lumps	☐	☐	
LUNGS:			
Shortness of breath	☐	☐	
Wheezing, or asthma	☐	☐	
Frequent cough	☐	☐	
Productive cough	☐	☐	
Coughing up blood	☐	☐	
Pain while breathing/tightness in chest	☐	☐	
Bronchitis	☐	☐	
Pneumonia or pleurisy	☐	☐	
Tuberculosis or lung disease	☐	☐	
Chest x-ray in the past	☐	☐	

CONDITION	***YES***	***NO***	***HOSPITAL***
SKIN:			
Sores, slow to heal	☐	☐	
Problem with "easy bruising"	☐	☐	
Hives, eczema, or rash	☐	☐	
Chemical or jewelry rash/sensitivity	☐	☐	
Itching or excessive dryness	☐	☐	
Unusual spots or moles; any skin cancer	☐	☐	
Frostbite	☐	☐	
GASTROINTESTINAL:			
Nausea and/or vomiting	☐	☐	
Abdominal pain	☐	☐	
Change in bowel habit	☐	☐	
Rectal pain	☐	☐	
Hemorrhoids or piles	☐	☐	
Change in appetite	☐	☐	
Indigestion, pain or burning in stomach	☐	☐	
Black stools	☐	☐	
Bright red blood in stools	☐	☐	
Colitis or nervous stomach	☐	☐	
Ulcers or hiatal hernia	☐	☐	
Vomiting blood	☐	☐	
Pancreatitis	☐	☐	
Gall bladder trouble	☐	☐	
Diabetes or sugar in urine	☐	☐	
GENITOURINARY:			
Frequent or painful urination	☐	☐	
Bladder or kidney infection	☐	☐	
Blood in urine	☐	☐	
Difficulty starting or stopping stream	☐	☐	
Kidney stones	☐	☐	
Discharge or lesions	☐	☐	
Itching	☐	☐	
Sexually Transmitted Disease	☐	☐	
Hernia	☐	☐	
MUSCULOSKELETAL:			
Back trouble or back pain, back injury	☐	☐	
Surgery on back, arm, leg, or knee	☐	☐	
CONTINUE ON NEXT PAGE			

Print Applicant Name:

CONDITION	*YES*	*NO*	*HOSPITAL*
Any other surgery	☐	☐	
Sciatica	☐	☐	
Any defects of bones or joints (including amputations, broken bones or dislocations)	☐	☐	
Carpal tunnel	☐	☐	
Swelling or joint pain, lameness (limp)	☐	☐	
Torn ligaments/cartilage	☐	☐	
Trick or locked knee/knee injury	☐	☐	
Arthritis, rheumatism, bursitis, or gout	☐	☐	
Hand or wrist injury or problem	☐	☐	
Ankle or foot injury or problem	☐	☐	
Inability to assume certain positions	☐	☐	
Muscle weakness, rupture or hernia	☐	☐	
Fractures	☐	☐	
Dupuytren's Contracture	☐	☐	
CENTRAL NERVOUS SYSTEM:			
Seizure or blackouts	☐	☐	
Numbness, weakness, stroke, paralysis	☐	☐	
Tremors, tingling	☐	☐	
Memory loss	☐	☐	
Loss of balance	☐	☐	
Neurological disorder	☐	☐	
Psychiatric or emotional problem	☐	☐	
Depression or mental illness	☐	☐	
FOR FEMALES ONLY:			
Menstrual irregularities	☐	☐	
Recurrent problems of the female organs	☐	☐	
Breast masses or lumps	☐	☐	
Discharge from nipples	☐	☐	

CONDITION	*YES*	*NO*	*HOSPITAL*
Do you practice monthly breast self-exams	☐	☐	
Have you ever had a mammogram	☐	☐	
Date of last pap smear:			
FOR MALES ONLY:			
Breast tenderness, swelling, lumps	☐	☐	
Prostate or testicular problems	☐	☐	
Do you practice monthly testicular self-exams	☐	☐	
Breast tenderness, swelling, lumps	☐	☐	
GENERAL LIFESTYLE I:			
Do you exercise three times per week	☐	☐	
30-40 minutes each time	☐	☐	
Type of exercise:			
Are you 30% or more over your ideal weight	☐	☐	
Had a tetanus booster in the last 10 yrs.	☐	☐	
Had Hepatitis B immunization	☐	☐	
GENERAL LIFESTYLE II:			
Do you participate in a workplace wellness program?	☐ *Yes*	☐ *No*	
If offered, would you participate in:	☐ *Yes*	☐ *No*	
Blood pressure screen	☐ *Yes*	☐ *No*	
Blood pressure screen	☐ *Yes*	☐ *No*	
Weight loss	☐ *Yes*	☐ *No*	
Nutrition program	☐ *Yes*	☐ *No*	
Stress management	☐ *Yes*	☐ *No*	
Health risk appraisal	☐ *Yes*	☐ *No*	
Health education program	☐ *Yes*	☐ *No*	
Self-directed exercise	☐ *Yes*	☐ *No*	
Women's/Men's health	☐ *Yes*	☐ *No*	

SECTION A. *Continued*

Answer the following questions. If the answer is "YES", list the question number, the nature and date(s) in Section B.

	YES	*NO*
1. Have you ever had or been advised to have an operation?	☐	☐
2. Have you ever been a patient (committed or voluntary) in a mental hospital?	☐	☐
3. Have you ever had any other illness, injury, or physical condition not named on this form other than childhood diseases or minor illnesses?	☐	☐
4. Are you presently under a doctor's care for any condition?	☐	☐
5. Have you taken any medication during the last 12 months?	☐	☐
6. Do you have any physical or emotional limitations?	☐	☐

CONTINUE ON NEXT PAGE

Print Applicant Name:

PHYSICIANS CONSULTED: (For any of the questions answered "YES", identify the Physician consulted.)

DATE	*ITEM*	*PHYSICIAN*	*Telephone #* *(Include area code)*	*ADDRESS* *(Street, city, stat, zip code)*

I hereby authorize the above listed physician(s) to release any and all medical information to the hiring agency, its staff or designated representatives.

Signature of Applicant: *Date:*

SECTION B. *Write your own account and explain any items marked "YES" in this questionnaire; identify the question number, include diagnosis, date of onset, and your present condition.*

ITEM	***DETAILS (If necessary, continue on separate sheet of paper)***

MEDICATIONS

Do you take any prescription medication? YES ☐ NO ☐

Do you take any non-prescription medication? YES ☐ NO ☐

LIST MEDICATION (Include supplements and vitamins.)

MEDICATION	***DOSE***	***FREQUENCY***	***CONDITION***

ALLERGIES

Are you allergic to any medication, food, or environment? YES ☐ NO ☐ Specify:

☐ ***NO KNOWN DRUG ALLERGIES***

FAMILY HISTORY

	Yes	***No***	***Relationship to you***		***Yes***	***No***	***Relationship to you***
Diabetes	☐	☐		*Chronic Lung Disease*	☐	☐	
Heart attack or other heart ailment (<60 years)	☐	☐		*Congenital or Hereditary Disease*	☐	☐	
High blood pressure	☐	☐		*Cancer*	☐	☐	
Stroke	☐	☐		*Epilepsy*	☐	☐	
Sickle Cell	☐	☐		*Depression or Hereditary Disease*	☐	☐	
Tuberculosis	☐	☐		*Other:*			

SECTION B. Continued

	Yes	*No*	*Smoke*	*Chew*	*Dip/Snuff*	*Amount*	*How Long*
Do you currently use tobacco?	☐	☐	☐	☐	☐		
Have you used tobacco in the past?	☐	☐	☐	☐	☐		

	Yes	*No*	*Type*	*Frequency*	*Amount*	*How Long*
Do you use alcohol?	☐	☐				

WORK HISTORY

JOB DESCRIPTION	***YEARS (From – To)***	***EMPLOYER LOCATION***	***DESCRIPTION OF WORK***

Print Applicant Name:

OCCUPATIONAL EXPOSURE HISTORY (Please check all that apply.)			
Have you ever worked in or around the following?			
☐ *Chemical Plant*	☐ *Electronics Plant*	☐ *Foundry*	☐ *Refinery*
☐ *Construction site*	☐ *Farm*	☐ *Outdoor Areas*	☐ *Shipyards*
☐ *Cotton, Flax or Hemp Mill*	☐ *Fiber Mill*	☐ *Paper/Lumber Mill*	☐ *Dusty Jobs*
☐ *Coke oven*	☐ *Hazardous waste industry*	☐ *Hospital*	☐ *Metal production/ Smelter*
☐ *Mine*	☐ *Pottery mill*	☐ *Pharmaceuticals*	☐ *Sand pit or quarry*
☐ *Nuclear industry*	☐ *Rubber processing plant*	☐ *Plastic production*	☐ *Service station*
Other sites with hazardous exposure:			
Have you ever used or been exposed to the following chemicals or conditions?			
☐ *Aldrin*	☐ *Chloroprene*	☐ *Hexachlorobenzene*	☐ *PVC's*
☐ *Arsenic*	☐ *Chromates*	☐ *Isocyanates*	☐ *Radioactive Materials*
☐ *Arsine*	☐ *Chromic acid mist*	☐ *Lasers*	☐ *Roofing materials*
☐ *Asbestos*	☐ *Cutting oils*	☐ *Lead*	☐ *Rubber*
☐ *Benzene*	☐ *DDT*	☐ *Loud or continuous noise*	☐ *Silica*
☐ *Benzidene*	☐ *Dieldrin*	☐ *Mercury*	☐ *Solvents, Degreasers*
☐ *Beryllium*	☐ *Dioxin*	☐ *Methylene chloride*	☐ *Soots and tars*
☐ *BIS chlormethyl ether*	☐ *Dust, coal*	☐ *Microwaves*	☐ *Spray Painting*
☐ *Cadmium*	☐ *Ethyl dibromide*	☐ *Nickel*	☐ *Trichloroethylene*
☐ *Carbon disulfide*	☐ *Ethylene oxide*	☐ *PCB's*	☐ *Vibratory Equipment*
☐ *Carbon Tetrachloride*	☐ *Extreme heat or cold*	☐ *Pesticides*	☐ *Vinyl chloride*
☐ *Chlorine*	☐ *Fluorides*	☐ *Phenols*	☐ *Welding/Soldering*
☐ *Chlorodane*	☐ *Formaldehyde*	☐ *Phosgene*	☐ *Other Heavy Metals*
☐ *Chloroform*	☐ *Heptachlor*	☐ *Plastics*	☐ *Roofing materials*
☐ *Other:*			
List any toxins/chemicals/biological hazards you might currently be exposed to:			
Do you have (or have you ever had) any hobbies/recreational activities that include:			
☐ *Loud noises* ☐ *Weight lifting (to pounds)* ☐ *High risk activities (i.e. skydiving, scuba diving, etc.) Specify:*			

Have you ever received medical surveillance (periodic check-ups or tests) as part of a job?	☐ *Yes*	☐ *No*
Have you ever been injured on a previous job and treated by a doctor?	☐ *Yes*	☐ *No*
Have you ever been restricted in your work or given light duty?	☐ *Yes*	☐ *No*
Have you ever left a job because of health problems?	☐ *Yes*	☐ *No*
Have you ever received compensation for an industrial illness/injury?	☐ *Yes*	☐ *No*
Do you moonlight or have a second job?	☐ *Yes*	☐ *No*
Have you been hospitalized in the last five years?	☐ *Yes*	☐ *No*
Have you had any illness or injury not asked about?	☐ *Yes*	☐ *No*

Please explain any yes answers:

Have you used personal protective equipment for prior jobs? (Check all that apply.)

☐ *Gloves* ☐ *Hearing Protection* ☐ *Protective Clothing* ☐ *Respirator/SCBA* ☐ *Safety Goggles/Glasses*

Other:

PENALTY: *Any falsification, withholding or failure to answer all questions completely and accurately may cause forfeiture of eligibility.*

CERTIFICATION: *I certify that there are no willful misrepresentations, omissions or falsifications in the foregoing statements and answers to the questions, and that all statements and answers are true and correct to the best of my knowledge and belief. I also agree to have any future physical examinations my agency may deem necessary. I hereby give East Valley Wellness Center and its health care professionals permission to release work-related information to my employer, or to the company for which I am a job applicant.*

Signed by: _____ _____

Patient Signature ***Date***

EAST VALLEY WELLNESS CENTER
Gary A. Smith, MD, FAAFP
P.O. Box 52992 Phone: 480-373-2399
Mesa, AZ 85208 evwellness.com Fax: 480-373-2396

RESPIRATOR QUESTIONNAIRE

Name: _____ **Employee #:** _____

Agency: _____

Employer: Certain responses or patterns of response, to this questionnaire may lead the reviewer to request further information, or a medical examination, in order to reach a conclusion regarding the employee's ability to safely use a respirator, mask or SCBA.

Employee: Please complete this questionnaire prior to your medical examination.

Part A. (Mandatory)
Every employee who uses any type or respirator must provide the following information.

1. Today's Date: _____ **2. Name:** _____

3. Age: _____ **4. Sex:** _____

5. Height: _____ **ft.** _____ **in.** **6. Weight:** _____ **lbs.**

7. Job title: _____

8. Phone number you can be reached at by the healthcare provider who reviews this questionnaire:
Phone #: _____

9. Circle the type of respirator that you will be using (you may check more than one category)

a. ☐ N, R, P or disposable respirator (filter-mask, non-cartridge type only)

b. ☐ Other type (e.g. half or full-face piece type, powered-air purifying, supplied-air, self contained breathing apparatus)

10. Have you worn a respirator? ☐ Yes ☐ No
If yes, what type(s):

Print Applicant Name:

Part A. Section 2. (Mandatory)		
Every employee who has been selected to use **any** type of respirator must answer questions 1 through 9 below:		
	Yes	No
1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?	☐	☐
2. Have you ever had any of the following conditions?		
a. Seizures (fits):	☐	☐
b. Diabetes (sugar disease):	☐	☐
c. Allergic reactions that interfere with your breathing:	☐	☐
d. Claustrophobia (fear of closed-in places):	☐	☐
e. Trouble smelling odors:	☐	☐
3. Have you ever had any of the following pulmonary or lung problems?		
a. Asbestosis:	☐	☐
b. Asthma:	☐	☐
c. Chronic bronchitis:	☐	☐
d. Emphysema:	☐	☐
e. Pneumonia:	☐	☐
f. Tuberculosis:	☐	☐
g. Silicosis:	☐	☐
h. Pneumothorax (collapsed lung):	☐	☐
i. Lung cancer:	☐	☐
j. Broken ribs:	☐	☐
k. Any chest injuries or surgeries:	☐	☐
l. Any other lung problem that you've been told about?	☐	☐
4. Do you currently have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath:	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground:	☐	☐
d. Have to stop for breath when walking at your own pace on level ground:	☐	☐
e. Shortness of breath when washing or dressing yourself:	☐	☐
f. Shortness of breath that interferes with your job:	☐	☐
g. Coughing that produces phlegm (thick sputum):	☐	☐
h. Coughing that wakes you early in the morning:	☐	☐
i. Coughing that occurs mostly when you are lying down:	☐	☐
j. Coughing up blood in the last month:	☐	☐
k. Wheezing:	☐	☐
l. Wheezing that interferes with your job:	☐	☐
m. Chest pain when you breathe deeply:	☐	☐
n. Any other symptoms that you think may be related to lung problems:	☐	☐

Print Applicant Name:

Part A. Section 2. (Mandatory continued)		
5. Have you ever had any of the following cardiovascular or heart problems?		
	Yes	No
a. Heart attack:	☐	☐
b. Stroke	☐	☐
c. Angina:	☐	☐
d. Heart failure:	☐	☐
e. Swelling in your legs or feet (not caused by walking):	☐	☐
f. Heart arrhythmia (heart beating irregularly):	☐	☐
g. High blood pressure:	☐	☐
h. Any other heart problem that you've been told about:	☐	☐
6. Have you ever had any of the following cardiovascular or heart problems?		
a. Frequent pain or tightness in your chest:	☐	☐
b. Pain or tightness in your chest:	☐	☐
c. Pain or tightness in your chest that interferes with your job:	☐	☐
d. In the past two years, have you noticed your heart skipping or missing a beat:	☐	☐
e. Heartburn or indigestion that is not related to eating:	☐	☐
f. Any other symptoms that you think may be related to heart or circulation problems:	☐	☐
7. Do you currently take medication for any of the following problems?		
a. Breathing or lung problems:	☐	☐
b. Heart trouble:	☐	☐
c. Blood pressure:	☐	☐
d. Seizures (fits):	☐	☐
8. If you've used a respirator or SCBA, have you ever had any of the following problems?		
a. Eye irritation:	☐	☐
b. Skin allergies or rashes:	☐	☐
c. Anxiety:	☐	☐
d. General weakness or fatigue:	☐	☐
e. Any other problem that interferes with your use of a respirator:	☐	☐
9. Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire?	☐	☐

CONTINUE TO NEXT PAGE -
TUBERCULOSIS EVALUATION QUESTIONNAIRE

TUBERCULOSIS SCREENING QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth: _____ Employee #: _____

Positive TB skin test (PPD) Date: _____

Last Chest X-Ray Date: _____

Please indicate if you are having any of the following problems for three weeks or longer:

1. Chronic cough	☐ Yes	☐ No
2. Production of sputum	☐ Yes	☐ No
3. Blood-streaked sputum	☐ Yes	☐ No
4. Unexplained weight loss	☐ Yes	☐ No
5. Fever	☐ Yes	☐ No
6. Fatigue/Tiredness	☐ Yes	☐ No
7. Night sweats	☐ Yes	☐ No
8. Shortness of breath	☐ Yes	☐ No