# FIREFIGHTER EXAMINATION FORM

**Name**

**SS#**

**Date of Exam**

**Employer**

**Position/Job Title:**

**Type of Exam** □ Preplacement □ Periodic □ Other

## SMOKING HISTORY

<table>
<thead>
<tr>
<th>Current Smoker</th>
<th># cigarettes/day</th>
<th>total yrs. smoked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Former Smoker</td>
<td># cigarettes/day</td>
<td>total yrs. smoked</td>
</tr>
<tr>
<td>Never Smoked</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Current Smoker** # cigarettes/ day total yrs. smoked

**Former Smoker** # cigarettes/ day total yrs. smoked

**Never Smoked**

## ALCOHOL HISTORY

**What is your average alcohol consumption (drinks/week)?**

**If you drink, what is your usual pattern of drinking?** □ Weekdays □ Weekends □ Both

## DRUG HISTORY

**Do you use recreational drugs?** □ No □ Yes □ Describe

## EXERCISE HISTORY

**Type of exercise or activity you do**

**Intensity?** □ Low (walking) □ Moderate (jogging/cycling) □ High (sustained heart rate)

**Duration of exercise in minutes/session - days/week -**

## MEDICATIONS

**List all current medications**

## IMMUNIZATIONS

**Date of last tetanus shot**

**Received Hepatitis B Vaccine?** □ No □ Yes - completed series □ Series not completed

**If vaccinated against Hepatitis B did you get a titer?** □ No □ Yes – Result

## GENERAL MEDICAL HISTORY

**Have you ever been treated with an organ transplant, prosthetic device or an implanted pump or electrical device?** □ Yes □ No

**Have you had or have you been advised to have any operations?** □ Yes □ No

**Have you ever been a patient in any type of hospital after childhood?** □ Yes □ No

**Have you consulted or been treated by health care workers within the past year for other than minor illnesses?** □ Yes □ No

**Have you ever been rejected or discharged from military service due to physical, mental or other reasons?** □ Yes □ No

## PATIENT QUESTION

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>Any eye disease?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>WNL Abnl Head/face/neck/scalp</td>
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</table>

**WNL** Abnl Head/face/neck/scalp

**Abnl**

## PHYSICIAN EXAMINATION

### VISUAL ACUITY

[Snellen Machine](#)

**Corrected** □ **Uncorrected** □

**R 20/** □ **L 20/** □

**B 20/** □

### COLOR VISION

**Normal – red/green/amber**

### DEPTH PERCEPTION

**Far VA uncorrected at least 20/100** □

**Far VA corrected at least 20/40** □

**Color Normal – red/green/amber** □

**Peripheral vision at least 85°** □

**Depth perception at least 6/9** □

## AUDIOMETRIC STUDIES

**AUDIOMETRIC STUDIES**

**Audiogram** □ **Done** □ **Not Done**

**R-500** 1K 2K 3K

**L-500** 1K 2K 3K

**WHISPER** WNL Abnl

**Dilated Arteries**

**Done** □ **Not Done**

**Results:**

**Systolic** □ **Diastolic** □

**HT** □ **BP** □

**WT** □ **P** □

**RESP** □ **TEMP** □

## VITAL SIGNS

**EKG** □ **Done-attached** □ **Not Done**

**CXR** □ **Done** □ **Not Done**

**Results:**

**WNL** Abnl

**Abnl**

**Heart**

**EKG**

**VITAL SIGNS:**

**HT** □ **BP** □

**WT** □ **P** □

**RESP** □ **TEMP** □

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**EKG** □ **Done-attached** □ **Not Done**

**CXR** □ **Done** □ **Not Done**

**Results:**
# EXAMINING PROVIDER'S SUMMARY

- **A. NO SIGNIFICANT FINDINGS.** The individual appears to meet the medical standards. There is no apparent reason why the examinee cannot perform the functional requirements of a firefighter.
- **B. SIGNIFICANT FINDING (uncorrected Far Vision).** The individual does not meet the uncorrected far vision standard. An acceptable accommodation may be to require the possession during duty hours of a second set of corrective lenses. With this accommodation, there is no apparent reason why the examinee cannot perform the functional requirements of a firefighter.
- **C. SIGNIFICANT MEDICAL FINDINGS.** The individual does not appear to meet one or more of the medical standards, or is not considered able to safely participate in arduous duty performance testing.
- **D. FINAL DETERMINATION CANNOT BE MADE BASED ON AVAILABLE MEDICAL INFORMATION.** The results were inclusive and require that further information be provided to the examiner from the examinee's personal health care provider. Final recommendations cannot be made until this has been accomplished.

Examining Provider's Signature: ____________________________ Date: ________________

Patient's Signature: ____________________________ Staff Signature: ____________________________