COMPREHENSIVE FIRE FIGHTER HEALTH HISTORY QUESTIONNAIRE

Name_____ Today's Date_____

D.O.B._____ Sex M_____ F_____ Employer:_____

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PAST HEALTH HISTORY

YOUR PAST HISTORY OF MEDICAL PROBLEMS, ILLNESSES, INJURIES, SURGERIES AND HOSPITALIZATIONS

Please mark with an (X) any of the following illnesses and medical problems you ever had and indicate approximately the year each started.

Illness	(x)	(Year)	Illness	(x)	(Year)	Illness	(x)	(Year)
Glaucoma	___	_____	Irregular heart beat	___	_____	Anemia	___	_____
Cataracts	___	_____	Stomach/duodenal ulcer	___	_____	Bleeding tendency	___	_____
Other eye problems	___	_____	Diverticulosis	___	_____	Blood Transfusion	___	_____
Ear trouble	___	_____	Hiatal Hernia	___	_____	Thyroid trouble	___	_____
Deafness or decreased hearing	___	_____	Colitis	___	_____	Diabetes	___	_____
Bronchitis	___	_____	Acid Reflux	___	_____	Alcoholism	___	_____
Emphysema	___	_____	Other bowel problem	___	_____	Osteoporosis	___	_____
Pneumonia	___	_____	Hepatitis	___	_____	Chicken Pox	___	_____
Hay Fever	___	_____	Liver trouble	___	_____	Mononucleosis	___	_____
Asthma	___	_____	Gallbladder trouble	___	_____	Venereal Disease	___	_____
Asbestosis	___	_____	Hernia	___	_____	Genital Herpes	___	_____
Pneumothorax (collapsed lung)	___	_____	Hemorrhoids	___	_____	Gynecological/Obstetrical Problems	___	_____
Lung Cancer	___	_____	Kidney Stone	___	_____	Breast Problems	___	_____
Broken Ribs	___	_____	Kidney or bladder disease	___	_____	Phlebitis/Varicose Veins	___	_____
Any Chest Injuries /Surgeries	___	_____	Prostate Problem	___	_____	AIDS	___	_____
Aware of Any Lung Problem	___	_____	Psychiatric condition	___	_____	Medical Disorder Not Listed	___	_____
Tuberculosis	___	_____	Headaches	___	_____	_____	___	_____
Other lung problems	___	_____	Head injury	___	_____	_____	___	_____
High Blood Pressure	___	_____	Stroke	___	_____	_____	___	_____
Heart attack / Angina	___	_____	Convulsions, seizures	___	_____	_____	___	_____
Arteriosclerosis (hardening of arteries)	___	_____	Arthritis	___	_____	_____	___	_____
Pacemaker	___	_____	Chronic back pain	___	_____	_____	___	_____
Heart Murmur	___	_____	Gout	___	_____	_____	___	_____
Other heart condition	___	_____	Multiple Sclerosis	___	_____	_____	___	_____
High Cholesterol	___	_____	Depression / Anxiety	___	_____	_____	___	_____
Rheumatic fever	___	_____	Skin Conditions	___	_____	_____	___	_____
			Cancer or Tumor	___	_____	_____	___	_____

PLEASE LIST ALL TIMES YOU HAVE BEEN HOSPITALIZED, OPERATED ON, OR SERIOUSLY INJURED.

Year	Operation, Illness, Injury
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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GENERAL HEALTH

How is your general health now? Poor_____ Fair_____ Good_____ Excellent_____

Are you currently being treated for any medical illness? _____ Explain_____

In the past year:

Has your appetite changed? ..... Decreased_____ Increased_____ Stayed Same_____

Has your weight changed?..... Lost_____ lbs. Gained _____ lbs. No change_____

Are you thirsty much of the time?..... No_____ Yes_____

Has your overall "pep" changed? ..... Decreased _____ Increased_____ Stayed Same_____

Have you had chills or sweat at night?..... Yes_____ No_____

Have you had any lumps in your neck? ..... Yes_____ No_____

Armpits or groin? ..... Yes_____ No_____

Do you usually have trouble sleeping..... Yes_____ No_____

Do you exercise?..... Type_____ Hrs./Day_____Days/Week_____

How much coffee or tea do you usually drink?_____ cups of coffee or tea a day.

Do you smoke?..... Yes_____ No_____ If yes, how many years?_____

How many each day?..... _____ Cigarettes _____Cigars _____ Pipes Full

Do you drink alcoholic beverages?..... Yes_____ No_____ Drink ____ Beers ___Glasses of Wine____Hard Liquor per day.

HAVE YOU EVER

Had a problem with alcohol?..... Yes_____ No_____ Do you regularly wear seatbelts?.....Yes_____ No_____

Had a problem with drugs? ..... Yes_____ No_____

OCCUPATIONAL

Have you ever been restricted in your work or given "light duty" because of your health or injury? Yes_____ No_____

Have you ever left a job because of health problems? Yes_____ No_____

Have you ever been on the job and treated by a doctor? Yes_____ No_____

Have you ever received compensation for an industrial injury or illness? Yes_____ No_____

Do you plan to use SCBA? Yes_____ No_____

Are you a structural "indoor" firefighter? Yes_____ No_____

Have you ever worked or spent time near loud machinery? Yes_____ No_____

Have you worn a respirator? Yes_____ No_____ If "Yes" what type(s)?_____

Check the type of respirator you will use (you can check more than one category)

a). _____N, R. or P disposable respirator (filter mask. Non-cartridge type only).

b)._____ Other type (for example, half or full facepiece type, powered - air purifying, supplied air, scba.

How often are you expected to use the respirator(s)? (Check Yes or No for all answers that apply to you)

Escape only (no rescue) Yes_____ No_____ Less than 2 hours per day Yes_____ No_____

Emergency rescue only Yes_____ No_____ 2 to 4 hours per day Yes_____ No_____

Less than 5 hours per week Yes_____ No_____ Over 4 hours per day Yes_____ No_____

WORK HISTORY - START WITH MOST RECENT

DATE (YEAR TO YEAR)	COMPANY	POSITION	ANY WORK EXPOSURES/INJURIES

REVIEW OF BODY SYSTEMS

Do you have any problems with:

EYE TROUBLE

Last eye exam - Year _____ Date_____

Loss of Vision in either eye ❑ Yes ❑ No

❑ Temporarily ❑ Permanently

Wear glasses	❑ Yes	❑ No
Wear contacts	❑ Yes	❑ No
Vision changed in last year	❑ Yes	❑ No
Double vision	❑ Yes	❑ No
Blurred vision	❑ Yes	❑ No
Watery/itchy eyes	❑ Yes	❑ No
Sees halos	❑ Yes	❑ No

EAR TROUBLE

Hearing problem	❑ Yes	❑ No
Wear a hearing aid	❑ Yes	❑ No
Wax in ears	❑ Yes	❑ No
Discharge from ears	❑ Yes	❑ No
Loses balance	❑ Yes	❑ No
Dizzy/motion sickness	❑ Yes	❑ No
Ringing in ears	❑ Yes	❑ No

RESPIRATORY / LUNG TROUBLE

Shortness of breath	❑ Yes	❑ No
With what activity?_____		
Allergic reactions which interfere with your breathing	❑ Yes	❑ No
Cough blood	❑ Yes	❑ No
Wheezing/asthma/bronchitis	❑ Yes	❑ No
Hyperventilation	❑ Yes	❑ No
Fainting	❑ Yes	❑ No

CARDIOVASCULAR

Heart Trouble	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
Out of breath quickly when exercising	❑ Yes	❑ No
Chest/shoulder pains in exercise	❑ Yes	❑ No
Breathing problems during sleep	❑ Yes	❑ No
Sit up at night to breath easier	❑ Yes	❑ No
Restless sleeper	❑ Yes	❑ No
Leg cramps at night	❑ Yes	❑ No
Swollen ankles/feet	❑ Yes	❑ No
Rapid or irregular heartbeat	❑ Yes	❑ No
Dizziness	❑ Yes	❑ No
Fainted	❑ Yes	❑ No
Pains in thighs or legs when walking	❑ Yes	❑ No

URINARY

Hard to start urine flow	❑ Yes	❑ No
Painful urination	❑ Yes	❑ No
Frequency while awake	❑ Yes	❑ No
Frequency while asleep	❑ Yes	❑ No
Urine dark color, or bloody	❑ Yes	❑ No
Lose urine: strain, laugh, cough, sneeze	❑ Yes	❑ No
Lose urine: sleep		

GENITAL

Prostate trouble	❑ Yes	❑ No
Trouble with sex organs	❑ Yes	❑ No
Sores or lesions on penis	❑ Yes	❑ No
Discharge from penis	❑ Yes	❑ No
Pain or swelling in testicles	❑ Yes	❑ No
Sexual problems or impotency	❑ Yes	❑ No

GYNECOLOGICAL

Irregular period	❑ Yes	❑ No
Last menstrual period	❑ Yes	❑ No
Menstrual problems	❑ Yes	❑ No
Heavy menstrual bleeding	❑ Yes	❑ No
Discharge from nipple	❑ Yes	❑ No
Self Breast exam monthly	❑ Yes	❑ No
Breast lumps	❑ Yes	❑ No
Vaginal itching, discharge, burning	❑ Yes	❑ No
Estrogen replacement	❑ Yes	❑ No
Are you currently pregnant	❑ Yes	❑ No

PREGNANCY HISTORY

Times pregnant _____ Living children _____

Miscarriage_____ Abortions____ Premature births_____

MUSCULOSKELETAL

Weakness in any of your arms or legs	❑ Yes	❑ No
Back Pain	❑ Yes	❑ No
Difficulty fully moving when you lean forward or backward at the waist	❑ Yes	❑ No
Difficulty fully moving your head up or down	❑ Yes	❑ No
Difficulty fully moving your head side to side	❑ Yes	❑ No
Difficulty bending at your knees	❑ Yes	❑ No
Difficulty squatting to the ground	❑ Yes	❑ No
Climbing a flight of stairs or ladder carrying more than 24 lbs.	❑ Yes	❑ No
Any other muscle or skeletal problem that interferes with using a respirator	❑ Yes	❑ No

SKIN

Problem	❑ Yes	❑ No
Dry skin/brittle fingernails	❑ Yes	❑ No
Bruise easily	❑ Yes	❑ No
Mole change	❑ Yes	❑ No
Sores/cuts hard to heal	❑ Yes	❑ No
Herpes simplex	❑ Yes	❑ No

NEUROLOGICAL

Faintness	❑ Yes	❑ No
Numbness	❑ Yes	❑ No
Convulsions	❑ Yes	❑ No
Tremors	❑ Yes	❑ No
Coordination problems	❑ Yes	❑ No
Weakness/Paralysis	❑ Yes	❑ No

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DATE OF MOST RECENT DIAGNOSTIC TESTS

EKG_____ **Chest X-Ray**_____ **Blood Tests**_____ **Stress Test**_____ **Dental Exam**_____ **PSA**_____

Mammogram_____ **Colonoscopy**_____ **Pap Smear**_____ **Rectal Exam**_____ **Breast Exam** _____

YOUR FAMILY'S HEALTH HISTORY

Please give the following information about your immediate family.

Relationship	Age If Living	Age At Death	State of Health Or Cause of Death
Father			
Mother			
Brothers			
Sisters			
Children			

Have any Blood relatives (mother, father, sisters, brothers) had any of the following illnesses?
If so, indicate relationship (mother, brother, etc.)

Illness	Family Member
High Blood Pressure	
Heart Disease	
Stroke	
Cancer of any Kind	
Diabetes	
Tuberculosis	
Psychiatric Problems	
Alcoholism	
AIDS	

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CURRENT MEDICATIONS

Please list all medications you are now taking, including those you buy without a doctor's prescription (such as aspirin, cold tablets or vitamin supplements)

List Name, Dosage and Times per day.

1._____ 4._____ 7._____

2._____ 5._____ 8._____

3._____ 6._____ 9._____

FOOD AND MEDICINE ALLERGIES

LIST ANYTHING THAT YOU ARE ALLERGIC TO AND INDICATE HOW EACH EFFECTS YOU.

Allergic To:

1._____ 2._____ 3._____ 3._____

Check off shots you have had & the approximate year:

Measles_____ Mumps_____ Rubella_____ Chicken Pox_____ Lyme_____

Tetanus_____ Pneumonia Vaccine_____ Flu_____ Hepatitis_____ Other_____

Have you had a Tuberculin (TB) skin test? NO_____ YES____ Date_____ of last TB skin test ❑ Pos. ❑ Neg. ❑ BCG

Have you had an HIV test? NO____ YES____ Date _____ ❑ Pos. ❑ Neg.

PHYSICIAN COMMENTS

_____

_____

_____

_____