Office of Human Resources
FIRE & RESCUE OCCUPATIONAL MEDICAL SERVICES
255 Rockville Pike, Suite 135, Rockville, MD 20850 • 240-777-5185

EMPLOYEE MEDICAL HISTORY

EMPLOYEE NAME: _____ DFRS ID NO.: _____

☐ MALE ☐ FEMALE POSITION: _____ DOB: _____

I. MEDICAL HISTORY HEALTH CONDITIONS	NEVER HAD	HAD BUT DO NOT HAVE NOW	NOW HAVE	DO NOT KNOW
CARDIOVASCULAR				
Elevated Blood Pressure				
Episodes of chest pain, tightness, discomfort				
Palpitations or irregular hearbeat				
Swelling of both feet, ankles or legs				
Heart Attack or Angina				
Enlarged Heart				
Heart Bypass surgery, angioplasty or blood vessel surgery				
Stroke				
Heart Murmurs				
Elevated Cholesterol				
Rheumatic Fever				
Other Heart Condition				
RESPIRATORY SYSTEM				
Persistent or severe cough				
Coughing up blood				
Shortness of breath				
Tuberculosis				
Pneumonia				
Asthma				
Emphysema				
Sinus, hay fever, seasonal allergies				
Sleep Apnea				
ENDOCRINE SYSTEM				
Diabetes				
Hypoglycemia (low blood sugar)				
Thyroid condition				
Unexplained Weight Gain				
Unexplained Weight Loss				
GASTROINTESTINAL SYSTEM				
Recurrent indigestion/heartburn				
Jaundice				

I. MEDICAL HISTORY HEALTH CONDITIONS	NEVER HAD	HAD BUT DO NOT HAVE NOW	NOW HAVE	DO NOT KNOW
EYES AND VISION				
Detached retina				
Eye Injury				
Eye Surgery				
Eye Disease / Blindness				
EARS AND HEARING				
Pressure in ears				
Ringing in ears				
Ear injury				
Ear aches				
Ear infections				
Ear drainage				
Hearing loss				
Change in hearing				
PSYCHOLOGICAL OR MOOD				
Persistent or severe difficulty sleeping				
Stress related disorder/Anxiety				
Suicidal/attempted suicide				
Persistent or severe depression/worry				
MUSCULO-SKELETAL (bones/joints)				
Swollen or painful joints				
Neck or upper back problem				
Low back pain or problem				
Shoulder pain or problem				
Wrist/hand/elbow pain or problem				
Knee pain or problem				
Foot/ankle pain or problem				
Gout				
Osteoporosis				
GENTRO-URINARY				
Breast mass/Cyst				
Testicular Mass				
Enlarged lymph nodes				
OTHER				
Anemia				
Hernia				

EMPLOYEE NAME: _____ DOB: _____

II. FAMILY HISTORY

	MOTHER		FATHER		MATERNAL GRANDMOTHER		MATERNAL GRANDFATHER		PATERNAL GRANDMOTHER		PATERNAL GRANDFATHER		BROTHERS/ SISTERS		NATURAL CHILDREN (BORN LIVE)	
	Died of	*History of*	*Died of*	*History of*	*Died of*	*History of*	*Died of*	*History of*	*Died of*	*History of*	*Died of*	*History of*	*Died of*	*History of*	*Died of*	*History of*
1. Heart Attack or Heart Disease																
2. High Blood Pressure																
3. Stroke																
4. Tuberculosis																
5. Severe Loss of Hearing Before Age 50																
6. Glaucoma																
7. Diabetes																
8. Lvier or Gall Bladder Disease/Condition																
9. Kidney Disease/Condition																
10. Convulsions/Epilepsy																
11. Blood or Lymph Disease/Condition																
12. Cancer																

III. SMOKING HISTORY

1. Do you smoke? ..... ☐ YES ☐ NO
2 Have you smoked in the past? ..... ☐ YES ☐ NO
3. If you now smoke, or smoked in the past, how many years total have you smoked? ..... _____
4. If you now smoke, or have smoked in the past, how many packs per day do/did you smoke on the average?
   ☐ Less than ½ pack ☐ 1 pack ☐ 1½ packs ☐ 2 packs ☐ 2½ packs ☐ 3 packs ☐ 3+ packs

The following questions refer to specific components of the periodic physical examination:

IV. GRADED EXERCISE TEST

1. Do you have any health problems today that may prevent you from walking or jogging on a treadmill? ..... ☐ YES ☐ NO
2 List any prescribed or over the counter medications you have taken in the past 24 hours: _____
   _____
3. How much caffeine (coffee, tea, soft drinks) have you consumed in the past 12 hours? _____
4. Have you exercised regularly in the past 2 months? ..... ☐ YES ☐ NO
   If yes, type of exercise: _____
   Days per week: _____ Minutes per day: _____

V. PULMONARY FUNCTION

1. In the past year, did you work at a "dusty" job? ..... ☐ YES ☐ NO
2. In the past year, have you been exposed to gas or chemical fumes in your work? ..... ☐ YES ☐ NO
   Type: _____ If YES, was exposure: ☐ Mild ☐ Moderate ☐ Severe
3. Do you wear a SCBA or other type of respirator on the job? ..... ☐ YES ☐ NO
   If yes, how often? _____ What kind? _____
4. Has there been any change in your health status since your previous respiratory fit test? ..... ☐ YES ☐ NO
   If yes, please describe: _____

VI. HEARING

1. Do you have a cold today? ..... ☐ YES ☐ NO
2. Have you been exposed to loud noise within the past 24 hours? ..... ☐ YES ☐ NO
3. In general, is your workplace loud? ..... ☐ YES ☐ NO
4. Does your worksite provide hearing protection for you? ..... ☐ YES ☐ NO
5. Do you wear hearing protection at work? ..... ☐ YES ☐ NO
6. During the past year have you been exposed to any of the following noises:
   Firearms/guns ..... ☐ YES ☐ NO Motorcycles: ..... ☐ YES ☐ NO Power Tools (chains saws, etc.) ..... ☐ YES ☐ NO
   Power Lawn Equipment ..... ☐ YES ☐ NO Loud Music: ..... ☐ YES ☐ NO Other_____

Employee Signature: _____ Date: _____ 6/06