**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: Click here to enter name DFRS ID NO#: Click here to enter

[ ]  Male [ ]  Female Position: Click here to enter position DOB: Click here to enter a date

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **I. MEDICAL HISTORY** | **NEVER****HAD** | **HAD BUT DO NOT HAVE NOW** | **NOW****HAVE** | **DO NOT KNOW** | **I. MEDICAL HSITORY** | **NEVER HAD** | **HAD BUT DO NOT HAVE NOW** | **NOW****HAVE** | **DO NOT KNOW** |
| **HEALTH CONDITIONS** |  |  |  |  | **HEALTH CONDITIONS** |  |  |  |  |
| **CARDIOVASCULAR** |  |  |  |  | **EYES AND VISION** |  |  |  |  |
| Elevated Blood Pressure |[ ] [ ] [ ] [ ]  Detached Retina |[ ] [ ] [ ] [ ]
| Episodes of chest pain, tightness, discomfort |[ ] [ ] [ ] [ ]  Eye Injury |[ ] [ ] [ ] [ ]
| Palpitations or irregular heartbeat |[ ] [ ] [ ] [ ]  Eye Surgery |[ ] [ ] [ ] [ ]
| Swelling of both feet, ankles, or legs |[ ] [ ] [ ] [ ]  Eye Disease/ Blindness |[ ] [ ] [ ] [ ]
| Heart Attack or Angina |[ ] [ ] [ ] [ ]  **EARS AND HEARING** |  |  |  |  |
| Enlarged Heart |[ ] [ ] [ ] [ ]  Pressure in ears |[ ] [ ] [ ] [ ]
| Heart Bypass surgery, angioplasty, or blood vessel surgery |[ ] [ ] [ ] [ ]  Ringing in ears |[ ] [ ] [ ] [ ]
| Stroke |[ ] [ ] [ ] [ ]  Ear injury |[ ] [ ] [ ] [ ]
| Heart Murmurs |[ ] [ ] [ ] [ ]  Ear aches |[ ] [ ] [ ] [ ]
| Elevated Cholesterol |[ ] [ ] [ ] [ ]  Ear infections |[ ] [ ] [ ] [ ]
| Rheumatic Fever |[ ] [ ] [ ] [ ]  Ear drainage |[ ] [ ] [ ] [ ]
| Other Heart Condition |[ ] [ ] [ ] [ ]  Hearing loss |[ ] [ ] [ ] [ ]
|  |  |  |  |  | Change in hearing |[ ] [ ] [ ] [ ]
| **RESPIRATORY SYSTEM** | **PSYCHOLOGICAL OR MOOD** |
| Persistent or severe cough |[ ] [ ] [ ] [ ]  Persistent or severe difficulty sleeping |[ ] [ ] [ ] [ ]
| Coughing up blood |[ ] [ ] [ ] [ ]  Stress related disorder/ Anxiety |[ ] [ ] [ ] [ ]
| Shortness of breath |[ ] [ ] [ ] [ ]  Suicidal/ attempted suicide  |[ ] [ ] [ ] [ ]
| Tuberculosis |[ ] [ ] [ ] [ ]  Persistent or severe depression/ worry |[ ] [ ] [ ] [ ]
| Pneumonia |[ ] [ ] [ ] [ ]  **MUSCULOSKELETAL (bones/joints)** |
| Asthma |[ ] [ ] [ ] [ ]  Swollen or painful joints |[ ] [ ] [ ] [ ]
| Emphysema |[ ] [ ] [ ] [ ]  Neck or upper back problem |[ ] [ ] [ ] [ ]
| Sinus, hay fever, seasonal allergies |[ ] [ ] [ ] [ ]  Low back pain or problem |[ ] [ ] [ ] [ ]
| Sleep Apnea |[ ] [ ] [ ] [ ]  Shoulder pain or problem |[ ] [ ] [ ] [ ]
|  |  |  |  |  | Wrist/ hand, elbow problem |[ ] [ ] [ ] [ ]
| **ENDOCRINE SYSTEM** | Knee pain or problem |[ ] [ ] [ ] [ ]
| Diabetes |[ ] [ ] [ ] [ ]  Gout |[ ] [ ] [ ] [ ]
| Hypoglycemia (low blood sugar) |[ ] [ ] [ ] [ ]  Osteoporosis |[ ] [ ] [ ] [ ]
| Thyroid condition |[ ] [ ] [ ] [ ]  **GENTRO- URINARY** |
| Unexplained weight gain |[ ] [ ] [ ] [ ]  Breast mass/ Cyst |[ ] [ ] [ ] [ ]
| Unexplained weight loss |[ ] [ ] [ ] [ ]  Testicular Mass |[ ] [ ] [ ] [ ]
|  |  |  |  |  | Enlarged lymph nodes |[ ] [ ] [ ] [ ]
| **GASTROINTESTINAL SYSTEM** | **OTHER** |
| Recurrent indigestion/ heartburn |[ ] [ ] [ ] [ ]  Anemia |[ ] [ ] [ ] [ ]
| Jaundice |[ ] [ ] [ ] [ ]  Hernia |[ ] [ ] [ ] [ ]

**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** |
| **Heart Attack or Heart Disease** |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| **High Blood Pressure** |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| **Stroke** |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| **Tuberculosis** |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| **Severe Loss of Hearing Before Age 50** |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| **Glaucoma** |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| **Diabetes** |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| **Liver or Gall Bladder Disease/ Condition** |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| **Convulsion/ Epilepsy** |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| **Blood or Lymph Disease/ Condition** |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| **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 packs per day do/ did you smoke on average?

[ ]  Less than ½ pack [ ]  1 pack [ ]  1 ½ pack [ ]  2 packs [ ]  2 ½ pack [ ]  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 on a treadmill? [ ]  Yes [ ]  No
2. List any prescribed or over the counter medications you have taken in the past 24 hours: Click here to enter medications
3. How much caffeine (coffee, tea, soft drinks) have you consumed in the past 12 hours? Click here to enter
4. Have you exercised regularly in the past 2 months? [ ]  Yes [ ]  No

If yes, type of exercise: Click here to enter type of exercise

Days per week: Click here to enter Minutes per day: Click here to enter

**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: Click here to enter type If YES, was exposure: [ ]  Mild [ ]  Moderate [ ]  Severe

1. Do you wear a SCBA or other type of respirator on the job? [ ]  Yes [ ]  No

If YES, how often? Click here to enter What kind? Click here to enter

1. Has there been any change in your health status since your previous respiratory fit test? [ ]  Yes [ ]  No

If YES, please describe: Click here to 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 (chain saws, etc.) [ ]  Yes [ ]  No

Power Lawn Equipment [ ]  Yes [ ]  No Loud Music [ ]  Yes [ ]  No OtherClick here to enter

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: Click here to enter a date