**FIRE RESCUE OCCUPATIONAL MEDICAL SERVICES**

**OFFICE OF HUMAN RESOURCES**

**MONTGOMERY COUNTY, MARYLAND**

**INTERVAL MEDICAL HISTORY FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **LAST NAME**  Click here to enter last name | | **FIRST NAME**  Click here to enter first name | | **MIDDLE INITIAL**  Click here to enter middle initial | **TODAY’S DATE**  Click here to enter a date. |
| **SEX**  Click here to enter text. | **DOB**  Click here to enter DOB | **HOME ADDRESS**  Click here to enter address | | | |
| **POSITION TITLE**  Click here to enter title | | **DEPARTMENT**  Click here to enter department | | **WORK SITE**  Click here to enter work site | |
| **SUPERVISOR NAME AND PHONE**  Click here to enter name and phone number. | | | **HOME PHONE**  Click here to enter home phone | **WORK PHONE**  Click here to enter work phone | **CELL PHONE**  Click here to enter cell phone |
| **PURPOSE OF EXAM (CHECK APPROPRIATE EXAM)**  Return to Work Periodic  Work Related Fitness for Duty  Non-Work Related  Light Duty  Other | | | | **NAME ADDRESS OF PERSONAL HEALTH CARE PROVIDER**  Click here to enter name and address | |
| YES  NO Have you seen any Physician, Psychiatrist, or other Health Care Provider for evaluation or treatment since your last visit here? If yes, please complete the following:  Date: Click here to enter date.  Name and Address of Health Care Provider: Click here to enter text.  Reason for Visit: Click here to enter text. | | | | | |
| YES  NO Have you missed more than 3 consecutive days of work due to illness or injury since your last visit here? If yes, complete the following:  Date: Click here to enter work phone  Number of Days Missed: Click here to enter work phone | | | | | |
| YES  NO Are you currently on restricted duty? If yes, please state type of restrictions, reason, and earliest date your Health Care Provider has advised you may be able to return to full, unrestricted duty.    Click here to enter text. | | | | | |
| YES  NO Do you currently have any claims pending for Workmen’s Compensation Disability?  If yes, please give details, including nature of injury, date of injury, and name and address of Health Care Provider treating you.  Click here to enter text. | | | | | |
| YES  NO Do you currently have an application or appeal for Disability Retirement? If yes, please give details including nature of condition, date of application, and name and address of physician treating you.  Click here to enter text. | | | | | |
| YES  NO Are you currently on any prescribed or over the counter medications or special diets?  If yes, please complete the following:  Name of Medication or diet: Purpose Name and address of prescribing physician/ nurse practitioner    Click here to enter text. | | | | | |
| YES  NO Do you have any additional information regarding your health which you wish to make part of your permanent health record?  If yes, give details below:  Click here to enter text. | | | | | |
| YES  NO Are you currently in good health to the best of your knowledge and belief?  Make any comments below.  Click here to enter text. | | | | | |
| YES  NO Are you currently a volunteer for a Montgomery County Fire Corporation? | | | | | |

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I agree to sign all appropriate “Release of Information Forms” to allow the release of all necessary medical information to be used by the Employee Medical Examiner to evaluate my fitness for duty or other work- related health issues if necessary.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Click here to enter a date.

Social Security Number Click here to enter Social Security Number.