GRIFFIN HEALTH
Occupational Medicine
& Rehabilitation Services

FIREFIGHTER Medical Record

Name:		Date:
Address:	City:	State, Zip:
Phone (Home/Cell):	(work):	Sex: F M
Email Address:		DOB:
Primary Care Provider:		Town of Primary Care Provider:
Date of Last Physical with your Primary Care Provider:		
Family History: (Circle) Heart Disease Cancer Diabetes Stroke		
Dominate Hand: (Circle) Left Right		

List Any Hospitalizations or surgery you have had in the past

Date	Reason

Are you currently taking any Medication including prescriptions, vitamins, and supplements? **Yes** **No**
If yes, what are they:_____

_____

Do you smoke tobacco? **Yes** **No** If yes, # of packs per day_____ / Years_____

If you smoked in the past, when did you quit? _____

Do you use any addictive substances? **Yes** **No**

How much alcohol do you drink? None 1-7 drinks per week 8-14 drinks per week 15+ drinks per week

How many days of work did you miss in the past 12 months due to illness or injury?_____

Have you been in the military service? Yes No Branch of service:_____

How long? _____ Assignment:_____

List any health issues you have:

☐NONE

Do you have any allergies to medication, food or chemical? If so, please describe reaction:

☐NONE

Firefighter duties applied for: Interior, Exterior, Fire-Police?

What do you do for work?

Please check if you have or have had any in the past:

1	Weight loss > 10lbs w/o diet		28	Breast lumps		55	Frequent diarrhea		82	Head injury	
2	Recent weight gain of > 10lbs		29	Breast surgery		56	Hepatitis or jaundice		83	Concussion	
3	Change in appetite		30	Frequent coughs		57	Hernia		84	Loss of consciousness	
4	Persistent fatigue		31	Bronchitis		58	Kidney infection		85	Memory loss	
5	Night sweats		32	Emphysema		59	Bladder infection		86	Sleep disturbance	
6	Skin rash		33	Asthma or wheezing		60	Kidney stones		87	Nervousness	
7	Glaucoma/cataracts		34	Pneumonia		61	Painful urination		88	Mental illness	
8	Wear glasses or contacts		35	Coughed up blood		62	Bloody urine		89	Fear of heights	
9	Blurred vision / double vision		36	High blood pressure		63	Urinating frequently night		90	Diabetes	
10	Eyes sensitive to light		37	Shortness of breath		64	Discharge from penis		91	Thyroid problems	
11	Sinus pain		38	Sleep on 2 more pillows		65	Arthritis		92	Goiter	
12	Ear surgery		39	Heart attack		66	Tendonitis/bursitis		93	Rheumatic fever	
13	Ear pain or discharge		40	Stroke		67	Swelling of joints		94	Polio	
14	Ear infection		41	Chest pain / angina		68	Fracture		95	Tuberculosis	
15	Frequent/ severe headache		42	Palpitation / heart flutter		69	Dislocation of joint		96	Venereal disease	
16	Dizziness		43	Heart murmur		70	Arm pain		97	Cancer	
17	Fainting		44	Calf pain		71	Arm/leg weakness		98	Multiple sclerosis	
18	Hearing aid		45	Ankle swelling		72	Weakness/tingling fingers		99	Carpal tunnel syndrome	
19	Change in hearing		46	Blood clots		73	Hand surgery		100	Silicosis	
20	Anorexia		47	Repeated infection		74	Knee injury/surgery		101	Asbestosis	
21	Bulimia		48	Frequent indigestion		75	Foot problems		102	Seizures/convulsions	
22	Recurrent mouth sores		49	Stomach pain		76	Muscle spasm			**For Women**	
23	Bleeding gums		50	Vomited blood		77	Back pain/injury		103	Problems with periods	
24	Difficulty swallowing		51	Change in bowl habits		78	Back surgery		104	Pregnancies #_____	
25	Persistent hoarseness		52	Bloody/black bowl		79	Tremors		105	Problems with pregnancy	
26	Neck injury		53	Frequent constipation		80	Anemia		106	Are you pregnant now	
27	Neck radiation		54	Hemorrhoids		81	Blood transfusion		107	Last menstrual period Date:	

Please circle if you have ever had the following:

Been, or now involved in litigation for personal injury	Yes	No		Been made ill by your work	Yes	No
Been discharged from the military for health reasons	Yes	No		Received workers compensation	Yes	No
Been rejected from the military for health reasons	Yes	No		Filed workers compensation claim	Yes	No
Been refused employment for health reasons	Yes	No		Been refused life insurance	Yes	No
Been forced to give up a job for health reasons	Yes	No		Collected pension for disability	Yes	No
Moved from your home because of health risks	Yes	No		Worked with radioactive material	Yes	No

Explain:_____

_____

_____

_____

_____

_____

_____

Patient Name:_____ DOB:_____

Communicable Disease History:

Please circle if you have ever had:

Scarlet Fever	Yes	No
Measles	Yes	No
German Measles	Yes	No
Mumps	Yes	No
Chicken Pox	Yes	No
Hepatitis	Yes	No
Covid-19	Yes	No

Immunization Record:

☐ Vaccinated as a child in the USA

MMR Vaccine _____ / _____ / _____

Hepatitis B Vaccine _____ / _____ / _____

Flu Vaccine _____ / _____ / _____

Varicella Vaccine _____ / _____ / _____

Tetanus Toxoid _____ / _____ / _____

COVID-19 Vaccine _____ / _____ / _____

Medical History:

Please circle if you have or have had in the past:

Shortness of Breath at rest or exertion?	Yes	No
Chest Pain at rest or exertion?	Yes	No
Dizziness?	Yes	No
Palpitations or Racy Heart?	Yes	No
Back or Neck Injury or Pain?	Yes	No
Joint or Muscle Injury or Pain?	Yes	No
Do you have any Hernias?	Yes	No
History of Motor Vehicle Accidents?	Yes	No
History of any Sport Injuries?	Yes	No

The statements made on this form are true and complete.

_____ _____

Signature of patient **Date**

Section below to be completed by office:

Explanation of positive answers from page 2 & 3: _____

_____

_____

_____

_____

_____

_____

Signature of person reviewing form: _____ **Date:** _____

Patient Name:_____ DOB:_____

Physical Examination:

(To be completed by Medical Provider)

Height: ft in	Weight: lbs	BP:	Temp: °F	HR:
BMI:		Repeat BP:	RR:	Pulse Ox: %

Vision:	Uncorrected	Corrected	Comments:
Right Eye:	20 / ____	20/ ____	
Left Eye:	20 / ____	20 / ____	
Both Eyes:	20 / ____	20 / ____	
Near Vision:	20 / ____	20 / ____	

Peripheral Vision: Right Eye: _____° Left Eye: _____°

Color Blind Test: Can the firefighter distinguish between Red, Yellow, and Green? YES / NO

	Normal	Abnormal	Explanation
Head: a. Eyes b. Ears			
Neck: a. Thyroid/ Lymphatics b. ROM c. Scar			
Lungs/Chest:			
Heart:			
Abdomen: a. Masses b. Hernias c. Scars			
Extremities: (Include ROM for knees) a. Reflexes / Strength b. Range of Motion			
Back: a. Movement/ROM b. Posture c. Scars			

Patient Name:_____ DOB:_____

Are there any musculoskeletal problems that would affect the individual's physical capability to do THIS job?

Circle: Yes No Explain:_____

_____

_____

Work Limitations for current position: Explain: _____

_____

_____

Any additional comments: _____

_____

_____

Is this person medically qualified for this job placement: Circle Yes No Pending Explain: _____

_____

_____

_____ _____

Signature of Medical Provider **Date:**

Patient Name:_____ **DOB:**_____