LEWIS COUNTY VOLUNTEER FIREFIGHTER/EMS RESPONDER
MEDICAL EVALUATION FORM

FOR APPOINTMENT: Call Lewis County General Hospital Occupational Medicine: 315-376-5242

Fire Department: _____

CIRCLE ONE: FIREFIGHTER or EMS RESPONDER

Name:_____ Male_____ Female_____

Address: _____ D.O.B: _____

_____

Applicant Signature: _____ Phone #: _____

By signing this document the Fire Department Chief hereby certifies that the above named individual is a lawful applicant of your fire department.

Fire Chiefôs Name: _____ Date: _____

Fire Chiefôs Signature: _____

Firefighter:
A firefighter must be able to wear appropriate personal protective gear such as full firefighter turn out gear or self-contained breathing apparatus to perform firefighter roles such as but not limited to pump operations, aerial apparatus operations, and support roles on the fire ground. They must be able to pick up hose lines & equipment, and may be required to load trucks with tools & hose lines, etc.

EMS Responder:
EMS Responder will perform only EMS duties; must have ability to respond in varied environmental conditions. EMTôs are separate evaluations and must meet NYS physical requirements for certification.

Medical Examiner: Based on my evaluation, the above listed Firefighter or EMS Responder applicant:

( ) Has no medical or physical condition, which, in my opinion, would interfere with the performance of his/her firefighting or EMS duties.
( ) Has a medical or physical condition, which in my opinion, would interfere with the performance of his/her firefighting or EMS duties.

Healthcare Provider (MD, PA, NP): _____

Signature: _____ Date: _____

Attn: Medical Examiner: The extensiveness of the physical examination given should be based on the Firefighter/EMS Responder physical duties, age and health status. If, in your medical opinion, further testing is required, please initial below and advise applicant/patient.

Medical Examiner Initials: _____

LEWIS COUNTY VOLUNTEER FIREFIGHTER/EMS RESPONDER
PHYSICAL QESTIONNAIRE

Ï Yes Ï No Do you currently smoke tobacco, or have you smoked tobacco in the last month?
Ï Yes Ï No Have you ever had any of the following conditions?
Ï Seizures Ï Diabetes Ï Allergic reactions that interfere with your breathing (list source) _____ Ï Claustrophobia Ï Trouble smelling odors
Ï Yes Ï No Have you ever had any of the following pulmonary or lung problems?
Ï Asbestosis Ï Asthma Ï Chronic bronchitis Ï Emphyysema Ï Pneumonia Ï Tuberculosis Ï Silicosis Ï Pneumothorax Ï Lung cancer Ï Broken ribs Ï Any chest injuries or surgeries Ï Any other lung problem
Ï Yes Ï No Do you currently have any of the following symptoms of pulmonary or lung illness?
Ï Shortness of breath Ï Shortness of breath when walking fast on level ground or walking up a slight incline Ï Shortness of breath when walking with other people at an ordinary pace on level ground Ï Have to stop for breath when walking at your own pace on level ground Ï Shortness of breath when washing or dressing yourself Ï Shortness of breath that interferes with your job Ï Coughing that produces phlegm Ï Coughing that wakes you early in the morning Ï Coughing that occurs mostly when you are lying down Ï Coughing up blood in the last month Ï Wheezing Ï Wheezing that interferes with your job Ï Chest pain when you breathe deeply Ï Any other symptoms that you think may be related to lung problems
Ï Yes Ï No Have you ever had any of the following cardiovascular of heart problems?
Ï Heart attack Ï Stroke Ï Angina Ï Heart failure Ï Swelling in your legs or feet (not caused by walking) Ï Heart arrhythmia Ï High blood pressure Ï Any other heart problems that youôve been told about
Ï Yes Ï No Have you ever had any of the following cardiovascular or heart symptoms?
Ï Frequent pain or tightness in your chest Ï Pain or tightness in your chest during physical activity Ï Pain or tightness in your chest that interferes with your job Ï In the past two years, have you noticed your heart skipping or missing a beat Ï Heartburn or indigestion that is not related to eating Ï Any other symptoms that you think may be related to heart or circulation problems
Ï Yes Ï No Do you currently take medication for any of the following problems?
Ï Breathing or lung problems Ï Heart trouble Ï Blood pressure Ï Seizures
Ï Yes Ï No Have you ever lost vision in either eye (temporarily or permanently)?
Ï Yes Ï No Do you currently have any of the following vision problems?

Ĭ Wear contact lenses Ĭ Wear glasses Ĭ Color blind Ĭ Any other eye or vision problem
Ĭ Yes Ĭ No Have you ever had an injury to your ears, including a broken ear drum?
Ĭ Yes Ĭ No Do you currently have any of the following hearing problems?
Ĭ Difficulty hearing Ĭ Wear a hearing aid Ĭ Any other hearing or ear problem
Ĭ Yes Ĭ No Have you ever had a back injury?
Ĭ Yes Ĭ No Do you currently have any of the following musculoskeletal problems?
Ĭ Weakness in any of your arms, hands, legs, or feet Ĭ Back pain Ĭ Difficulty fully moving your arms and legs Ĭ Pain or stiffness when you lean forward or backward at the waist Ĭ Difficulty fully moving your head up and down Ĭ Difficulty fully moving your head side to side Ĭ Difficulty bending at your knees Ĭ Difficulty squatting to the ground Ĭ Climbing a flight of stairs or a ladder carrying more than 25 lbs Ĭ Any other muscle or skeletal problem not listed above
Ĭ Yes Ĭ No Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures, are you taking any other medications for any reason (including over-the-counter medications) If ñyesò, name the medications if you know them: _____

CLINICAL/MEDICAL EVALUATION

Check each item in proper column.

Height:			Respirations:		
Weight:			Blood Pressure:		
Temperature:			Heart Auscultation:		
Pulse:			Resp. Auscultation (Rt/Lf):		
	Normal	Abnormal		Normal	Abnormal
Head, Neck, Face & Scalp			Abdomen & Viscera (incl. hernia)		
Nose & Sinuses			Anorectal (pilonidal)		
Mouth & Throat			Endocrine System		
Teeth & Gingive			G-U System		
Lungs			Upper Extremities		
Breast Exam			Lower Extremities		
Heart			Spine		
Vascular System (vasicosites, etc)			Skin & Lymphatic		
Psychiatric			Neurologic		

Healthcare Provider (MD, PA, NP): _____

Signature: _____ Date: _____