



71 Prospect Ave, Hudson, NY 12534 | 518-828-7601

AUTHORIZATION FOR FIREFIGHTER PHYSICAL

To be completed by Fire Company and given to firefighter to hand in at check in for physical.

Facility: (Please check)

- Valatie Rapid Care (Call for appointment: 7 days a week 518-697-3356)
2827 Route 9, Valatie
- Copake Rapid Care (Call for appointment: 7 days a week 518-697-3356)
283 Mountain View Rd, Copake
- Coxsackie Family Care
9 Law Street Coxsackie, NY 12051 (Call for appointment M-F 518-731-2120)

To Whom it May Concern:

Please perform a firefighter physical examination for _____,
who is a member or has applied for membership in the _____
Department and needs an annual physical exam.

Sincerely,

Shawn Rindell
Signature

Chief
Title

Date

To be completed by CMH: Physical Exam Acknowledgement

The above-named firefighter was given a firefighter physical exam on the following date: _____

Note: Respiratory FIT testing, Immunization requirements and Color Vision testing are not part of the firefighter exam and are at the discretion of the individual department policies and protocols.

Approved for: Category: A B C D or Failed (circle one)

Provider Name: _____ Signature: _____ Date: _____

DISABILITY HISTORY

Are you currently receiving any kind of subsidized disability payments, been declared permanently disabled, or have any physical/medical condition that would prevent you from holding a job and you are in the process of filing for disability?

YES, I am receiving disability and/or considered disabled.

NO, I am not receiving disability and/or considered disabled.

If marked YES, please give details to include the date that you were declared disabled and any description of the condition that is the source of the disability to the occupational health provider.

I am willing and provided information about my disability to the occupational health provider.

I am NOT willing and WILL NOT provide information about my disability to the occupational health provider.

YES NO I am authorizing release of this form to my department chief / administrator.

Name: _____ Date: _____

Signature: _____

PROVIDER ATTESTATION

The above named firefighter/applicant has provided information about their disability with me during the course of the physical. Based upon the provided information and results of the physical examination, I find that the firefighter/applicant will be able to safely perform the duties required of the firefighter classification being identified on page 1.

Signature: _____ Date: _____

CANCER HISTORY

Have you ever been treated or currently being treated for the following types of cancer:

YES NO Lung

YES NO Prostate

YES NO Breast

YES NO Lymphatic

YES NO Hematological

YES NO Digestive

YES NO Urinary

YES NO Neurological

YES NO Reproductive Systems

YES NO Melanoma

If any are marked YES, please give details to include the date when a diagnosis of cancer was made and the current status of treatment:

YES NO I authorize a copy to be given to my department chief or administrator

Name: _____ Date: _____

Signature: _____

1 copy in patient chart
1 copy to fire district (if Yes is checked)

COLUMBIA MEMORIAL HEALTH FIREFIGHTER EVALUATION FORM

PLEASE COMPLETE THE FOLLOWING INFORMATION

Fire Company: _____

Name: _____ Testing Location: _____

Social Security #: _____ / _____ / _____ Date of Birth: _____

Home Address: _____

Home Phone: _____ Primary Care Physician: _____

PCP (Primary Care Physician) Phone: _____

PCP Address: _____

Category A: Interior Firefighting: Must be able to utilize a respirator, carry injured victims and perform strenuous activity with no physical restrictions.

Category B: Exterior Firefighting: Must be able to perform strenuous physical exertion and have no limitations and be able to use an air pack. It is very similar to category A.

Category C: Exterior Support Activities: This individual must be able to fight brush fires, do extrication, assist at structure fires, do mountain rescue, rope rescue, water rescue, as well as drive. They do not require use of an Air pack. They must be physically capable of performing these strenuous activities.

Category D: Administrative/ Fire Police: Must be able to stand for long periods without a chair directing traffic. Must be physically capable of jumping to safety should a vehicle be at risk of hitting them. Canes, crutches, severe arthritis are all automatically disqualified.

Which Category are you currently ? A B C D None of these (circle one)

Which Category are you requesting ? A B C D None of these (circle one)

___ Fire Fighter Complete Exam				___ Peak Flow (>350) done	Pass	Fail	
___ EKG	Pass	Fail	N/A	___ Whisper Test (at 5 ft)	Pass	Fail	N/A
___ Urine Dip	Pass	Fail	N/A	___ Fingertstick Glucose	Pass	Fail	N/A

Note: Respiratory FIT testing, Immunization requirements and Color Vision testing are not part of the firefighter exam and are at the discretion of the individual department policies and protocols.

Comments:

Approved For Category: A B C D None

Provider Name: _____ **Signature of provider:** _____ **Date:** _____

Physical Questionnaire

Pulmonary

Have you ever had any of the following pulmonary or lung illnesses?

Yes ___ No ___ Asbestosis

Yes ___ No ___ Asthma

Yes ___ No ___ Broken Ribs

Yes ___ No ___ Chronic Bronchitis

Yes ___ No ___ Emphysema

Yes ___ No ___ Lung Cancer

Yes ___ No ___ Pneumonia Pneumothorax (collapsed lung)

Yes ___ No ___ Silicosis

Yes ___ No ___ Tuberculosis

Yes ___ No ___ Have you ever had any lung or chest surgeries or injuries?

If "Yes", please explain: _____

Yes ___ No ___ Have you ever had a chest X-Ray? Please give the approximate date of your most recent:

Date: _____ Was it NORMAL? ABNORMAL? NOT SURE? (please circle one)

Do you currently have any of the following symptoms of pulmonary or lung illness?

Yes ___ No ___ Shortness of Breath

Yes ___ No ___ Shortness of breath when walking fast on level ground to walking up a slight hill or incline

Yes ___ No ___ Shortness of breath when walking with other people at an ordinary pace on level ground

Yes ___ No ___ Have to stop for breath when walking at your pace on level ground

Yes ___ No ___ Shortness of breath when washing or dressing yourself

Yes ___ No ___ Shortness of breath that interferes with your job

Yes ___ No ___ Coughing that produces phlegm (thick sputum)

Yes ___ No ___ Coughing that wakes you early in the morning

Yes ___ No ___ Coughing up blood in the last month

Yes ___ No ___ Wheezing

Yes ___ No ___ Wheezing that interferes with your job

Yes ___ No ___ Chest pain when you breathe deeply

Yes ___ No ___ Allergic reactions that interfere with your breathing

Yes ___ No ___ Do you have any other lung problems that you have been told about?

If "Yes" Please explain: _____

Yes ___ No ___ Has your doctor recommended that you currently limit any of your work, recreation or hobby activities due to any of the lung problems listed above?

If "Yes" please explain: _____

Cardiovascular

Have you ever had any of the following cardiovascular or heart problems?

- Yes ___ No ___ Angina
- Yes ___ No ___ Coronary artery bypass surgery or an angioplasty/balloon catheterization YEAR _____
- Yes ___ No ___ Heart arrhythmia (irregular heart beat)
- Yes ___ No ___ Heart attack (MI)
- Yes ___ No ___ Heart Failure
- Yes ___ No ___ Heart Murmur
- Yes ___ No ___ High Blood Pressure
- Yes ___ No ___ Swelling in your legs or feet (not caused by walking)

Have you ever had any of the following cardiovascular or heart symptoms?

- Yes ___ No ___ Frequent pain or tightness in your chest at rest
- Yes ___ No ___ Pain or tightness in your chest during physical activity
- Yes ___ No ___ In the past two years, have you noticed your heart skipping or missing a beat
- Yes ___ No ___ Heartburn or indigestion that is related to physical activity
- Yes ___ No ___ Any other symptoms that you think may be related to heart or circulation problems:
Please explain: _____
- Yes ___ No ___ Have you ever had an EKG (electrocardiogram)? Please give the approximate date of your most recent EKG : _____
Was it NORMAL , ABNORMAL, DON'T KNOW (please circle one)
- Yes ___ No ___ Have you ever had a Stress Test or treadmill EKG (echocardiogram)? Please give the approximate date of your most recent stress test: _____
Was it NORMAL, ABNORMAL, DON'T KNOW (please circle one)

Neurologic

- Yes ___ No ___ Frequent headaches
- Yes ___ No ___ Multiple Sclerosis
- Yes ___ No ___ Paralysis/Spinal Cord injury
- Yes ___ No ___ Seizures/Epilepsy (fits)
- Yes ___ No ___ Stroke/ Cerebral Vascular Accident
- Yes ___ No ___ Any other neurological illness or injury? Please explain: _____
- Yes ___ No ___ Has your doctor recommended that you **currently** limit any of your work, recreation or hobby activities due to any of the neurological problems?
If "YES" Please explain: _____

Gastrointestinal/Kidney

Have you ever had the following Intestinal/Stomach/Kidney conditions?

- Yes ___ No ___ Appendicitis
- Yes ___ No ___ Gallbladder
- Yes ___ No ___ Hiatal Hernia
- Yes ___ No ___ Liver Disease (Cirrhosis, Hepatitis)
- Yes ___ No ___ Reflux (GERD)
- Yes ___ No ___ Ulcers
- Yes ___ No ___ Any other intestinal or kidney illness or injury? Please explain: _____
- Yes ___ No ___ Has your doctor recommended that you currently limit any of your work, recreation or hobby activities due to any of the intestinal or kidney problems listed? If "YES" please explain: _____

EYES

Do you currently have any of the following vision problems?

- Yes ___ No ___ Cataracts
- Yes ___ No ___ Color Blind
- Yes ___ No ___ Glaucoma
- Yes ___ No ___ Lost vision in either eye (temporarily or permanently?)
- Yes ___ No ___ Wear contact lenses or wear glasses
- Yes ___ No ___ Any other eye or vision problem? Please explain: _____

EARS

Do you currently have any of the following hearing problems?

- Yes ___ No ___ Broken ear drum
- Yes ___ No ___ Difficulty hearing _____ Left ear AND/OR _____ Right ear
- Yes ___ No ___ Ringing in the ears
- Yes ___ No ___ Wear a hearing aid
- Yes ___ No ___ Any other hearing or ear problems? Please explain: _____

Musculoskeletal

Do you currently have any of the following musculoskeletal problems?

- Yes ___ No ___ Arthritis
- Yes ___ No ___ Back pain, including sciatica, herniated or bulging disk, arthritis, or muscle strain
- Yes ___ No ___ Difficulty climbing a flight of stairs or ladder carrying more than 25 pounds
- Yes ___ No ___ Difficulty or weakness fully moving your arms and legs
- Yes ___ No ___ Difficulty bending at your knees
- Yes ___ No ___ Difficulty squatting to the ground
- Yes ___ No ___ Gout
- Yes ___ No ___ Pain or stiffness when you lean forward or backward at the waist
- Yes ___ No ___ Any other muscle or skeletal problem that interferes with performing work activities including using a respirator? : Please explain: _____
- Yes ___ No ___ Has your doctor recommended that you currently limit any of your work, recreation or hobby activities due to any of the musculoskeletal problems listed? If "YES" please explain: _____

General Medical

Do you have any of the following?

Yes ___ No ___ Anemia

Yes ___ No ___ Cancer

Yes ___ No ___ Claustrophobia (fear of closed-in places)

Yes ___ No ___ Diabetes (sugar disease)

Yes ___ No ___ Thyroid disease

Yes ___ No ___ Trouble smelling odors

Tobacco and Alcohol

Yes ___ No ___ Do you currently smoke tobacco

Yes ___ No ___ Have you in the past smoked tobacco

If you have smoked or do smoke, how many years have you smoked? _____

How many packs per day have/do you smoke _____

Yes ___ No ___ Do you drink alcohol

On the average, how much of the following do you drink per week?

Beer: _____ cans/bottles Wine: _____ glasses Whiskey/liquor: _____ jiggers/shots

Family Medical History

If a family member has had any of the following medical conditions, please write the number which corresponds to that family member in the space provided.

1. Father 2. Mother 3. Grandparents 4. Brother/Sister 5. Children

_____ Cancer _____ Liver Disease/Cirrhosis _____ Diabetes _____ Seizure/Epilepsy

_____ Hypertension _____ Heart Disease _____ Lung Disease

Yes ___ No ___ Is your father still living? If "NO", what age did he die? _____

What was the cause of his death? _____

Yes ___ No ___ Is your mother still living? If "NO", what age did she die? _____

What was her cause of death? _____

Respiratory Protection

Check the type of respirator you will use (you can check more than one category)

- a. _____ N, R, or P disposable respirator (filter- mask, non-cartridge type only)
- b. _____ Other type (for example: half- or full-face piece type, powered- air purifying, supplied air, self-contained breathing apparatus)

Yes ___ No ___ Have you worn a respirator? If "YES", please circle what type(s):

- Disposable/paper mask
- Filter/cartridge style or half or full face piece mask
- Military gas mask
- Self-Contained Breathing Apparatus (SCBA)
- Supplied- Air or Type C respirator

If you have used a respirator, have you ever had any of the following problems related to using respirator?

- Yes ___ No ___ Anxiety
- Yes ___ No ___ Eye Irritation/Difficulty seeing in your mask
- Yes ___ No ___ Shortness of breath
- Yes ___ No ___ Skin Allergies or rashes
- Yes ___ No ___ Any other problem that interferes with your use of a respirator?

Please explain: _____

Protective Equipment

- Yes ___ No ___ Do you have a latex or rubber sensitivity
- Yes ___ No ___ Do you get rashes after wearing protective clothes
- Yes ___ No ___ Do you become overheated wearing protective clothing

Health Status

Please indicate what you believe your health status is today: ___Excellent___ Good___ Fair___ Poor

Yes ___ No ___ Have you been examined or treated by a health care provider within the last 12 months for?

Injury (please explain) _____

Illness (please explain) _____

Routine physical or follow-up (please explain) _____

Surgical History

Please list any surgical procedure you have had and if possible, list dates (or approximate) dates:

_____	_____
Surgical procedure	Date
_____	_____
Surgical procedure	Date
_____	_____
Surgical procedure	Date
_____	_____
Surgical procedure	Date
_____	_____
Surgical procedure	Date
_____	_____
Surgical procedure	Date

Medication List

Please list any medications that you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

I have answered this health questionnaire completely and honestly and understand I can review any questions with my examiner if I am unsure or need to further explain.

Employee Signature: _____ Date: _____

Authorization for Release of Information

I, the undersigned, authorize the release of information to Columbia Memorial Hospital from:

Name/ Primary Care Provider : _____

Address : _____

City: _____ State _____ Zip Code _____

Telephone # (_____) _____ - _____ Fax # (_____) _____ - _____

I expressly authorize the release of the following information from my health file:

Print: _____

Print: _____

Sign: _____

Sign: _____

Date: ____ / ____ / ____

Date: ____ / ____ / ____

To the Recipient: This information has been disclosed to you from confidential records, which are protected by the federal and state law. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure is in violation of state and federal law and may result in a fine or jail sentence, or both.

AUDIOMETRIC EVALUATION

Name: _____ SSN: _____
 Employer: _____ Periodic []
 DOB: _____ Age: _____ Date: _____ Pre-employment []
 Occupation: _____ Re-test []

Please Circle answer to questions 1-11:

1. Have you had any loud noise exposure in the past 14 years (prior to test)? YES NO
2. Are you experiencing a ringing, buzzing, or plugging sensation in either ear today? YES NO
3. Do you ever have ringing in your ears? YES NO
4. Do you have a "head cold" or congestion today? YES NO
5. Have you ever been exposed to loud noise from military activities? YES NO
 If "YES", please explain the type of noise: _____
 Length of time (years) of exposure: _____ years
6. Have you ever worked a noisy job? YES NO
 If "YES" please explain: _____
 Length of time (years) of exposure: _____ years
7. Have you had regular exposure to any of the following non-occupational noise sources? :
 Power or Air tools _____ Target shooting or hunting _____ Chain Saws _____
 Motorcycles/snowmobiles _____ Loud Music _____ Other: _____
8. Have you ever been found to have a hearing loss? YES NO
 If "YES" please explain: _____
9. Does anyone in your family have a hearing loss? YES NO
10. Do you wear a hearing aid? YES NO
11. Have you ever had any of the following? :

Ear infections	YES	NO	Diabetes	YES	NO
Ear Injury	YES	NO	Head injury	YES	NO
Ear Surgery	YES	NO	Mumps/Measles/Scarlet Fever	YES	NO
Stroke	YES	NO			

Employee Signature: _____ Date: _____

Name: _____ Date: _____
 Employer: _____ DOB: _____
 Date of Exam: _____

PFT:
Reading #1 _____
Reading #2 _____
Reading #3 _____
Average : _____

Blood Pressure: _____ / _____ Pulse: _____ regular/irregular
 Height: _____ (in) Weight: _____ (lbs)
 Fingertick Glucose: Normal / Abnormal
 Urine Dip: Normal / Abnormal (presence of glucose, protein and/blood?)
Vision **Corrective lenses? Yes or No**

Vision	OD (Right)	OS (Left)	OU (both)
Distance	20/	20/	20/
Near	20/	20/	20/
Peripheral			

Hearing Perceives whisper at five (5) feet? AS Yes or No AD Yes or No

Physical Exam	Normal	Abnormal	Comments
1. Eyes			Abnormal discs or fundi? Unequal pupils? Cataracts?
2. Ears			TM Scarring? TM Perforation? Excess cerumen?
3. Mouth/Throat			Dentures? Poor dentition Ulcers? Erythema?
4. Neck			Lymph nodes? Thyroid? Bruit?
5. Lungs			Wheezes? Rales? Diminished breath sounds?
6. Heart			Murmur? Irregular rhythm?
7. Abdomen			Masses? Tenderness? Organomegaly? Hemia? Prostate? Stool guaiac?
8. Musculoskeletal			Clubbing? Edema? Deformity? Spine? Varicosities? Gait? Weakness? Atrophy? Decreased ROM?
9. Neurologic			Reflexes? Motor? Sensory? Cranials?
10. Skin			Scars? Moles? Rashes? Erythema? Excoriation? Scaling? Tattoos?

I certify that I have reviewed the examination form and performed a physical examination on this patient.

Examiner's Signature: _____ Date: _____

Title of Examiner: _____

A referral has been made for further evaluation to: _____

Comments: _____