

City of Conover Fire Department

Medical Examination Report

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT
BE RELEASED TO UNAUTHORIZED PERSONS

INSTRUCTIONS:

To be completed by either a physician/Physician's Assistant/Nurse Practitioner or Surgeon licensed to practice medicine in N.C. or by a physician and/or surgeon authorized to practice medicine in accordance with the rules and regulations of the U.S Armed Forces, [12NCAC9B .0104(a)], following an actual physical examination. The original or a copy of this report must be retained in a personnel file by the appointing agency

Date: _____ Last 4 Digits SSN: _____

Name: _____ Date of Birth: ____/____/____
Last First Middle

Height: _____ Weight: _____

- Well Nourished
- Obese
- Muscular

VISION

Visual Acuity: **If applicant wears glasses or contacts, test and record acuity with and without glasses**

Without glasses: R-20 / _____ L-20 / _____ Both-20 / _____

With glasses: R-20 / _____ L-20 / _____ Both-20 / _____

With contacts: R-20 / _____ L-20 / _____ Both-20 / _____

How long have contacts been worn: _____

Depth Perception: – Normal – Abnormal: _____

Color Perception: – Normal – Abnormal: _____

Peripheral Vision: – Normal – Abnormal: _____

HEARING

Hearing Acuity: – Audiogram - or - 15' whispered conversation (check one)

Right ear: – Normal – Abnormal: _____

Left ear: – Normal – Abnormal: _____

CARDIOVASCULAR

Blood Pressure: _____ Resting Pulse: _____

Cardiac Examination: – Normal – Abnormal: _____

Peripheral Circulation: – Normal – Abnormal: _____

ECG: – Indicated by hx or exam: _____ (If resting pulse is less than 50 or greater than 100)

ABNORMAL DETAILS

ABNORMAL

- HEENT: _____
- LUNGS: _____
- ABDOMEN: _____
- MUSCULOSKELETAL: _____
- GENITOURINARY: _____
- NEUROLOGICAL: _____
- SKIN: _____

URINALYSIS - Normal – Abnormal: _____

TB SKIN TEST - Negative – Positive: _____

Are there any conditions, physical, emotional, or mental, which, in your opinion, suggests further examination?

– No - Yes:

Do you have any reservations about this candidate’s ability to physically perform required duties?

– No - Yes:

I certify that this candidate is physically, mentally, and emotionally fit to perform the duties required in the CVCC Firefighter Academy.

Signature of Physician/Physician’s Assistant/Nurse Practitioner

Date

<p>Name and Address of Physician/Physician’s Assistant/Nurse Practitioner - Typed</p>
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Tuberculosis Risk Questionnaire

- 1) Were you born outside of the USA in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe? Yes / No
- 2) Have you traveled outside the USA and lived for more than one month in any of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe? Yes / No
- 3) Do you have a compromised immune system such as from any of the following conditions: HIV/AIDS, organ or bone marrow transplant, diabetes, immunosuppressive medicines (e.g. Prednisone, Remicade), Leukemia, Lymphoma, cancer of the head or neck, gastrectomy, jejunal bypass, end-stage renal disease (on dialysis), or silicosis? Yes / No
- 4) Have you ever done one of the following: used crack cocaine, injected illegal drugs, worked or resided in jail or prison, worked or resided in a homeless shelter, or worked as a healthcare worker in direct contact with patients? Yes / No
- 5) Have you ever been exposed to anyone with infectious tuberculosis? Yes / No

Tuberculosis Symptom Questionnaire

Do you have any of the following symptoms?

- 1) Unexplained cough lasting more than 3 weeks? Yes / No
- 2) Unexplained fever lasting more than 3 weeks? Yes / No
- 3) Night sweats (sweating that leave bedclothes and sheets wet)? Yes / No
- 4) Shortness of breath? Yes / No
- 5) Chest Pain? Yes / No
- 6) Unintentional weight loss? Yes / No
- 7) Unexplained fatigue (very tired for no reason)? Yes / No

All other Allergies: food, seasons, animals, materials, etc.: (include reactions)

Past Medical History

List **ALL** hospitalizations and operations since childhood:

(include type of surgery, date of surgery, any complications or other significant information)

Have you **EVER**, in your life, had any of the following types of medical problems? (check all that apply to you)

- CANCER:** any type of cancer including skin, breast, and leukemia?
- MAJOR INFECTIOUS DISEASE:** such as tuberculosis, hepatitis, HIV/AIDS, rheumatic fever and others?
- NEUROLOGICAL PROBLEMS:** such as seizure disorder, stroke, concussion, severe headache, skull fracture, recurrent vertigo, balance problems, encephalitis, meningitis, tremors, multiple sclerosis, Huntington's chores, peripheral neuropathy and others?
- PHYSIOLOGICAL PROBLEMS:** such as depression, manic episode, psychotic episodes, post traumatic stress disorder and others?
- EYE PROBLEMS:** such as ear injury, color blindness, poor night vision (night blindness), glaucoma, blindness in one or both eyes, very poor vision when not corrected and others?
- EAR PROBLEMS:** such as ear injury, chronic ringing(tinnitus), chronic or long-lasting ear infection, Meniere's disease, moderate to severe hearing loss in one or both ears and others?
- NOSE PROBLEMS:** such as nose injury, allergies, nasal bleeding, loss of sense of smell, chronic or long-lasting infections and others?
- MOUTH OR THROAT PROBLEMS:** such as injury, major dental work, any kind of speech defect, chronic or long-lasting infections, abnormality of nose, mouth or throat that would interfere with wearing a respirator and others?
- LUNG PROBLEMS:** such as asthma, emphysema, chronic or recurrent bronchitis, pneumonia, tuberculosis or lung abscess and others?
- HEART PROBLEMS AND CIRCULATION PROBLEMS:** such as heart murmur, heart disease, heart attack, irregular rhythm, valve abnormalities, varicose veins, phlebitis, peripheral vascular disease, Raynaud's disease and others?
- DIGESTIVE SYSTEM PROBLEMS:** such as any kind of kidney ulcer disease, hepatitis or liver disorder, any kind of colitis, Crohn's disease, ulcerative colitis, irritable bowel syndrome, esophageal disorders, pancreatitis, gall stones, stomach or intestinal bleeding and others?
- HORMONE OR ENDOCRINE PROBLEM:** such as diabetes, thyroid disease, parathyroid or adrenal problems and other?
- URINARY TRACT PROBLEMS:** such as kidney stones, pyelonephritis (kidney infection), nephrosis, single functioning kidney, polycystic kidney disease repeated bladder infections and others?
- HERNIA:** such as inguinal, umbilical, ventral, femoral, hiatal or incisional hernias?
- MUSCLE, BONE AND JOINT PROBLEMS:** such as chronic neck or back pain, fibromyalgia, back or neck disk disease, osteomyelitis (bone infection), muscular dystrophy, arthritis, spinal curvature, loss of finger or toe and others?
- BLOOD SYSTEM PROBLEMS:** such as anemia, hemophilia, or bleeding disorder, white blood cell abnormally and others?

MALES ONLY:

- Prostate problems such as enlargement or prostatitis?

- Genital problems such as epididymitis or testicular injury?

FEMALES ONLY:

- Currently pregnant?
- History of endometriosis, pelvic inflammatory disease, abnormal Pap smear, PMS or other problems with your menstrual cycle?

IMMUNIZATIONS:

- Have you ever had a positive TB test?
- Have you ever received the Hepatitis B vaccinations?
- When did you receive your last tetanus (lockjaw) immunization?

OCCUPATIONAL HISTORY

Have you ever been exposed to any of the following, whether at home, work, military or any other setting?
[check all that apply]

- Repetitive loud noises (including guns, jet engines, loud machinery)?
- Chemical exposure to skin or lungs?
- Dusty conditions (sandblasting, grinding, mining drilling of rock, coal, silica, asbestos)?

Check all YES answers:

- Have you ever sustained an injury while at work that necessitated extended care by a health care provider?
- Have you ever had a motor vehicle accident causing back or neck pain?
- Are you limited or unable to perform any physical activity because of muscle or joint discomfort?
- Do you have any missing limbs or non-functional joints?
- Have you ever been advised by a physician to avoid lifting above a certain weight?
- Have you ever been advised by a physician to avoid sitting or standing over a certain time?
- Have you ever worked in firefighting?
- If yes, have you ever missed more than three consecutive days of work for any medical or physiological problem?
- Have you ever served in any armed forces?
- If yes, have you ever missed more than three consecutive days of service for a medical or physiological problem?
- Have you ever passed out, temporarily lost control of any part of your body, or had blackout spells (episodes you do not remember)?

EXPLANATION OF ANY YES ANSWERS: (May use additional sheets of paper; write name, SS#, sign and date)

PENALTY:

Any falsification, withholding or failure to answer all questions completely and accurately may disqualify you from being accepted to the membership of Conover Fire Department.

CERTIFICATION:

I hereby certify that there are no willful misrepresentations, omissions, or falsifications in the foregoing statements and answers to questions and that all statements and answers are true and correct to the best of my knowledge and belief.

Signature of Applicant (ink)

Date Signed

PHYSICIAN REVIEW:

Signature of Physician/Physician's Assistant/Nurse Practitioner (ink)

Date Reviewed

Printed Name and Address of Physician/Physician's Assistant/Nurse Practitioner Completing Review
