# Woodlawn Volunteer Fire Company, Inc.
# Health Questionnaire

| Patient Name: | Date of Physical: |
|---|---|

| | |
|---|---|
| Physician's Name | |
| Physician's Address | |
| Physician's Telephone Number | |

**Personal Profile:**

| | |
|---|---|
| Date of Birth | |
| Place of Birth | |
| Military History | ☐ Yes ☐ No |
| Present Occupation | |
| Other Jobs you have held | |
| Highest Grade level completed | |
| Do you have any particular health concerns? | |

**Emergency Contact information**

| | |
|---|---|
| Name: | |
| Relationship: | |
| Home Phone number | |
| Work Phone number | |

**FUNCTIONAL MEDICAL HISTORY**
Please answer truthfully and completely. The information you provide is confidential.

**FAMILTY HISTORY**

| Has anyone in your family ever had: | Response | Who in your family? |
|---|---|---|
| Tuberculosis | ☐ Yes ☐ No | _____ |
| Heart Disease/Sudden death before age 50? | ☐ Yes ☐ No | _____ |
| Asthma | ☐ Yes ☐ No | _____ |
| Diabetes | ☐ Yes ☐ No | _____ |

## Serious Illness and/or Causes of Death

| Relationship | D.O.B | Age of Death | Cause of Death |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**YOUR PERSONAL HEALTH**

How many times have you been admitted to the hospital? _____

List hospitalizations, starting with the most recent

| Year | Reason | Hospital Name and Location |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Have you ever had or do you have:**

| | | |
|---|---|---|
| Concussions/Head injuries? | ☐ Yes | ☐ No |
| Loss of consciousness? | ☐ Yes | ☐ No |
| Date of most recent: _____ | | |
| Total # in past year: _____ | | |
| Contact lenses/glasses? | ☐ Yes | ☐ No |
| Wear during sports participation? | ☐ Yes | ☐ No |
| Burner/Stinger or any numbness? in the body? | ☐ Yes | ☐ No |
| Injury to neck? | ☐ Yes | ☐ No |
| Injury to shoulder(s)? | ☐ Yes | ☐ No |
| Injury to elbow(s)? | ☐ Yes | ☐ No |
| Injury to wrist/hand(s)? | ☐ Yes | ☐ No |
| Injury to back/spine? | ☐ Yes | ☐ No |
| Injury to chest/ribs? | ☐ Yes | ☐ No |
| Injury to hip/pelvis? | ☐ Yes | ☐ No |
| Injury to knee? | ☐ Yes | ☐ No |
| Injury to ankle/foot? | ☐ Yes | ☐ No |
| Stress fractures or fractures | ☐ Yes | ☐ No |
| Injury to eyes, ears, nose? | ☐ Yes | ☐ No |
| Became ill from exercising | ☐ Yes | ☐ No |
| Significant weight loss/gain? | ☐ Yes | ☐ No |
| Wear any protective equipment (knee braces, ankle braces, etc.)? | ☐ Yes | ☐ No |
| Take any Medications? | ☐ Yes | ☐ No |
| List medications: _____ | | |
| High Blood Pressure? | ☐ Yes | ☐ No |
| Any unhealed Injuries? | ☐ Yes | ☐ No |
| What is the injury? _____ | | |
| When did it occur? _____ | | |
| Have you ever been refused insurance or employment because of your health | ☐ Yes | ☐ No |
| Have you ever received disability payments | ☐ Yes | ☐ No |

**Females:**

| | | |
|---|---|---|
| Irregular or loss of Menstruation? | ☐ Yes | ☐ No |

**Have you ever had or do you have:**

| | | |
|---|---|---|
| Epilepsy or seizures? | ☐ Yes | ☐ No |
| Hepatitis/Jaundice/Liver Problem | ☐ Yes | ☐ No |
| Mononucleosis (Mono)? | ☐ Yes | ☐ No |
| Pneumonia? | ☐ Yes | ☐ No |
| Diagnosed with Heart condition? | ☐ Yes | ☐ No |
| Allergies (Bee stings, Medication, Food, etc)? | ☐ Yes | ☐ No |
| Bleeding? | ☐ Yes | ☐ No |
| Anemia? | ☐ Yes | ☐ No |
| Asthma? | ☐ Yes | ☐ No |
| Arthritis/Rheumatism/Grout | ☐ Yes | ☐ No |
| High Blood Pressure | ☐ Yes | ☐ No |
| Hernia(s)? | ☐ Yes | ☐ No |
| Diabetes? | ☐ Yes | ☐ No |
| Insulin dependent? | ☐ Yes | ☐ No |
| Hypoglycemia? | ☐ Yes | ☐ No |
| Shortness of breath? | ☐ Yes | ☐ No |
| Frequent Headaches? | ☐ Yes | ☐ No |
| Incidents of Dizziness? | ☐ Yes | ☐ No |
| Loss of paired body organ? | ☐ Yes | ☐ No |
| Thyroid Disease | ☐ Yes | ☐ No |
| Rhematic Fever | ☐ Yes | ☐ No |
| Stroke or Paralysis | ☐ Yes | ☐ No |
| Phlebitis/Varicose Veins | ☐ Yes | ☐ No |
| Emphysema | ☐ Yes | ☐ No |
| Tuberculosis | ☐ Yes | ☐ No |
| Pneumonia | ☐ Yes | ☐ No |
| Gallbladder trouble or Gallstones | ☐ Yes | ☐ No |
| Stomach trouble/Ulcers | ☐ Yes | ☐ No |
| Bowel Disorder/Colitis | ☐ Yes | ☐ No |
| Hemorrhoids | ☐ Yes | ☐ No |
| Cancer/Tumors | ☐ Yes | ☐ No |
| Kidney or Bladder trouble | ☐ Yes | ☐ No |
| Nervous/Emotional problems | ☐ Yes | ☐ No |
| Blood transfusion | ☐ Yes | ☐ No |

**Review of Systems**

**Have you *recently* had:**

| | |
|---|---|
| Unexpected weight change of more than 10 lbs. In the past year? | ☐ Yes ☐ No |
| Any serious problems with eyes, ears or nose? | ☐ Yes ☐ No |
| Any persistent swollen glands or unusual lumps? | ☐ Yes ☐ No |
| Any breast lumps or discharge? | ☐ Yes ☐ No |
| Your heart frequently racing or skipping beats? | ☐ Yes ☐ No |
| Pain or tightness in your chest with exertion? | ☐ Yes ☐ No |
| Frequent swelling of ankles or legs? | ☐ Yes ☐ No |
| Unusual or severe shortness of breath? | ☐ Yes ☐ No |
| Any unusual skin problems or persistent sores? | ☐ Yes ☐ No |
| Any redness, severe pain or swelling in your joints? | ☐ Yes ☐ No |
| Frequent or severe back pain? | ☐ Yes ☐ No |
| Frequent coughing or wheezing? | ☐ Yes ☐ No |
| Any serious difficulty swallowing? | ☐ Yes ☐ No |
| Frequent or severe stomach or abdominal pains? | ☐ Yes ☐ No |
| Frequent nausea or vomiting? | ☐ Yes ☐ No |
| Frequent or severe constipation or diarrhea? | ☐ Yes ☐ No |
| Blood or mucus in a bowel movement? | ☐ Yes ☐ No |
| A bowel movement that looked black tar? | ☐ Yes ☐ No |
| Any pain or burning with urination? | ☐ Yes ☐ No |
| Unusual frequency or amount of urination? | ☐ Yes ☐ No |
| Loss of control of your urine? | ☐ Yes ☐ No |
| Unusually frequent or severe headaches ? | ☐ Yes ☐ No |
| Serious sexual difficulties? | ☐ Yes ☐ No |
| Serious stress or depression from problems at home or work? | ☐ Yes ☐ No |

How many cigarettes do you smoke each day? # _____ Pipes? _____ Cigars? _____

Did you ever smoke more than you do now? ☐ Yes ☐ No

How much liquor do you drink each day? # _____ Beer? _____ Wine? _____

Did you ever drink more than you do now? ☐ Yes ☐ No

Have you ever used narcotics or other addictive drugs? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No If so, How often? _____

Have you ever been regularly exposed to any chemical, toxin, poisons, fumes, smoke or radioactive materials at home or work? ☐ Yes ☐ No

**List all drugs or medications that you use regularly ( include birth control pills and non-prescription items – laxatives, pain pills, cold tablets, etc.)**

_____

_____

_____

_____

**Please list any additional problems or special concerns about your health which you would like to discuss with your doctor.**

_____

_____

_____

_____

**VITAL SIGNS:**

| | |
|---|---|
| **Height** | **Pulse** |
| **Weight** | **Blood Pressure** |

**Circle if abnormal; Check if normal; underline if not done. Describe all abnormal and/or additional findings**

**GENERAL APPEARANCE**
**Comments:**

**SKIN**
**Comments:**

**LYMPATIC**
**Comments:**

**HEAD**
**Comments:**

**EYES**
**Comments:**

**FUNDI**
**Comments:**

**THROAT**
**Comments:**

**NECK**
**Comments:**

**BREASTS/BSE**
**Comments:**

**SPINE**
**Comments:**

**CHEST/LUNGS**
**Comments:**

**HEART**
**Comments:**

**ABDOMEN**
**Comments:**

**EXTREMITIES**
**Comments:**

**NEUROLOGIC**
**Comments:**

**GENITALIA**
**Comments:**

**P.V.S.**
**Comments:**

**RECTAL/OCCULT BLOOD**
**Comments:**

**ASSESSMENT:**

**PHYSICIAN'S SIGNATURE** _____ **DATE** _____

**STATEMENT OF CONFIDENTIALITY AND AUTHORIZATION TO RELEASE**

A complete history and medical record is maintained on each employee/volunteer of the Woodlawn Volunteer Fire Company, Inc. According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), all medical information is kept confidential and access is restricted to personnel that are responsible for your health care in relation to performance of your duties. Information, other than general injury information and participation status to Officers, will not be released without a written authorization of release. The authorization to release form must be signed by the member/employee, indicating what specific information is to be released, and who is to receive the information.

**MEDICAL CLEARANCE**

**Pre Participation Medical Clearance**: All employees/members must be medically cleared prior to the employment/membership with Woodlawn Volunteer Fire Company, Inc. This process includes completing required forms consisting of a Physical examination from your Medical Provider. A note of medical clearance is required from a Physician for Injuries and/or illnesses that were sustained since the last time you were medically cleared.

Applicant Signature: _____ Date: _____

Printed Name: _____