



Physical Exam Questionnaire

It is not necessary to forward this form.		Name:	
		Exam Date:	
		Medical Contact:	
Member's Health History	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	
Personal Physician:			
Medical Problems:			
Medications:			
Medication Allergies:			
NOTE: The patients' insurance company shall be billed for this exam. If the patients' insurance does not cover this exam, it is the patients' responsibility to pay for the exam and seek reimbursement through South Kitsap Fire and Rescue.			
Is there any present or past history of:			
1.	Major illness or injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Hospitalization or surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Back injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Do you drink 6 or more drinks per week (beer, wine, liquor)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Have you ever used tobacco (smoked or chewed)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Do you currently use tobacco (how much)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Heart disease, high blood pressure, or stroke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Blood, liver, kidney disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	Use of seat belts (always, mostly, some, none)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11.	Allergies, asthma, hay fever, eczema (Atopy)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12.	Skin disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13.	Heat injury (cramps, exhaustion, stroke)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14.	Lung or respiratory disease (COPD, bronchitis, pneumonitis)? (If yes, baseline chest X-ray needed.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15.	Headache, dizziness, light-headedness, weakness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16.	Cold injury (frostbite, chill, trench ft., hypothermia)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17.	Change or loss of vision?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18.	Loss or change in hearing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19.	Chest pain, angina, heart attack, palpitations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20.	Shortness of breath?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
21.	Epilepsy (seizure disorder)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
22.	Nervous disorder (gait change, numbness, weakness, coordination loss)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
23.	Thyroid disease (heat or cold intolerance)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
24.	Mental / emotional illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
25.	Occupational exposure to hazardous materials, toxin, ionizing radiation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
26.	Pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Explain "YES" answers:			
Signed:			Date: