Note: Print double sided

Health Center

New Patient Health Review

Cover Sheet

Please read the statement below before completing the attached form.

The Genetic Information Non-Discrimination Act (GINA)

"The Genetic Information Non-Discrimination Act" of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

In addition, you should have also received a copy of the Health Center's *Notice of Privacy Practices*.

Please sign below indicating that you have read and understand the information provided regarding the *GINA Act* and have received a copy of our *Notice of Privacy Practices*.

Printed Name: _____

Signature: _____

Date: _____

Please do not remove cover sheet.
Thank you!

Phoenix Fire Department Health Center

New Patient Health Review

Today's Date:

Personal Information:

Legal Name:

Last: First: M.I.

Nickname: SSN:

Date of Birth: Sex: M / F Marital Status:

Address:

City: State: Zip:

Home Phone: Cell: Pager:

Employer Information:

City of: Hire date:

Employer Phone:

Department/Station: Rank/Title:

Shift: Unit: (E, L, R, SQ, U) Employee I.D.#:
(City of Phoenix only)

Emergency Notification Information:

In case of emergency notify:

Relationship: Phone number:

Address:

City: State: Zip:

Blood Type Information:

Blood Type: Rh (+ or -)

Education Years: (Check highest level)

High School AA BA/BS MA/MS

Other Specify

Past Medical Problems/Hospitalizations/Surgeries: **YES** **NO**

If ***yes***, please give details below:

Date(s): Reason:

Date(s): Reason:

Date(s): Reason:

Date(s): Reason:

Date(s): Reason:

Date(s): Reason:

Are you <u>currently</u> experiencing any of the following?

Check all boxes that apply:

CONSTITUTIONAL

- Good general health lately
- Fever
- Fatigue
- Headaches

EYES

- Eye disease or injury
- Wear glasses/contact lenses
- Blurred or double vision

E.N.T.

- Hearing loss
- Ringing in ears
- Earaches or drainage
- Sinus problems
- Nose bleeds
- Bleeding gums
- Sore throat or voice change
- Swollen glands in neck

CARDIOVASCULAR

- Chest pain with exertion
- Sudden heartbeat changes
- Swelling of feet, ankles, hands

RESPIRATORY

- Frequent coughing
- Spitting up blood
- Asthma or wheezing

GASTROINTESTINAL

- Loss of appetite
- Change in bowel movements
- Nausea or vomiting
- Bloody or black stool
- Abdominal pain

GENITOURINARY

- Frequent urination
- Burning or painful urination
- Blood in urine
- Change of force of strain when urinating
- Incontinence or dribbling
- Kidney stones
- Sexual difficulty
- Male – testicle pain
- Female - # of pregnancies
- Female - # of miscarriages
- Female – date of last pap smear
- Female – findings of last pap smear
  Normal Abnormal

MUSCULOSKELETAL

- Joint pain
- Muscle pain or cramps
- Back pain

SKIN

- New suspicious lesions
- Rash or itching

NEUROLOGICAL

- Frequent or recurring headaches
- Light headed or dizzy
- Convulsions or seizures

PSYCHIATRIC

- Memory loss or confusion
- Anxiety
- Depression
- Sleep problems

ENDOCRINE

- Recent weight gain
- Excessive thirst or urination
- Heat or cold tolerance
- Dry skin
- Recent hair loss

HEMATOLOGIC/LYMPHATIC

- Slow to heal after cuts
- Easily bruise or bleed
- Enlarged lymph nodes

Please expand on any positive responses from above:

Allergies or Adverse Drug Reactions:

YES **NO**

Do you have any food, pollen, drug, etc. allergies?

Please list:

1. 4.
2. 5.
3. 6.

OSHA Respiratory Questionnaire:

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

		YES	NO
1.	Shortness of breath		
2.	Shortness of breath when walking fast on level ground or walking up a slight incline		
3.	Shortness of breath when walking with other people at an ordinary pace on level ground		
4.	Have to stop for breath when walking at your own pace on level ground		
5.	Shortness of breath when washing or dressing yourself		
6.	Shortness of breath that interferes with your job		
7.	Coughing that produces phlegm (thick sputum)		
8.	Coughing that wakes you early in the morning		
9.	Coughing that occurs mostly when you are lying down		
10.	Coughing up blood in the last month		
11.	Wheezing		
12.	Wheezing that interferes with your job		
13.	Chest pain when you breathe deeply		
14.	Any other symptoms that you think may be related to lung problems		

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

		YES	NO
1.	Frequent pain or tightness in your chest		
2.	Pain or tightness in your chest during physical activity		
3.	Pain or tightness in your chest that interferes with your job		
4.	In the past two years have you noticed your heart skipping/missing a beat		
5.	Heartburn or indigestion that is not related to eating		
6.	Any other symptoms you think may be related to heart or circulation problems		

If you've used a respirator, have you ever had any of the following problems?

		YES	NO
1.	Eye irritation		
2.	Skin allergies or rashes		
3.	Anxiety		
4.	General weakness or fatigue		
5.	Any other problem that interferes with your use of a respirator		

MEDICATIONS:

Prescription Medications	Dose	How often taken

NON-PRESCRIPTION: (over-the-counter medications) ex: aspirin, ibuprofen, vitamins, laxatives, etc.

Over-the-counter medications	Dose	How often taken

HERBAL PREPARATIONS: (over-the-counter medications) aspirin, ibuprofen, vitamins, laxatives, etc.

Herbal preparation	Dose	How often taken

Alcohol / Tobacco Use:

How many beers do you drink each week?
How many bottles of wine per week?
How many drinks of liquor per week?

Tobacco Current Use: Yes No

Do you currently use tobacco?
How many of the following do you smoke or chew per day?
Cigarettes Packs/day x years
Chew _ Cans/day x years

Tobacco Past Use: Yes No

Have you used tobacco in the past?
How many of the following do you smoke or chew per day?
Cigarettes Packs/day x years
Chew Cans/day x years
Quit Date

Fitness Review:

Please list your exercise activities and number of times per week you perform each.

Aerobic x week

Weight Training x week

Other:

Previous EMS/Fire Experience

If you have prior experience in the EMS and/or firefighting field, indicate the # of years in each field: Fire EMS

Indicate the cumulative # of years in each rank:

Firefighter Engineer Captain B/C Admin

Immunizations / Anti-toxins Review:

Check and write the date you most recently received the following:

Medication	Date(s)
Tetanus/Diptheria	
Poliomyelitis	
Influenza (flu shot)	
Hepatitis A vaccine	
Hepatitis B vaccine	
Measles, Mumps, Rubella (MMR)	
Varicella (Chicken Pox)	
BCG	
Small Pox	
RhoGAM (RH immune globulin)	
Gamma globulin (for hepatitis)	
Snake, black widow or scorpion antitoxin	
Mantoux, patch test, or other skin test for Tuberculosis	
Others:	

Prior Exposures/Disabilities:

Check if any of the following apply:

Have you ever worked with X-rays or radioactive materials?

Have you worked with asbestos or industry trade such as mining, foundry work, sand blasting or smelting?

Have you had any difficulties in having children (i.e. infertility, miscarriage, spontaneous abortion)?

Have you ever been exposed to any of the following chemical agents?

Acetone	Excessive noise	Petroleum products
Acetylene	Fluoride	Phosgene
Alkalis (ammonium or potassium hyrdrosxide)	Fluorine	Phosphoric acid
Allyl Chloride	Fluorocarbons	Phosphine
Ammonia	Formaldehyde	Radiation
Ammonium persulfate	Halogenated hydrocarbons	Silica, crystalline
Antimony	Helium	Silicon tetrachloride
Arsenic	Hydrazine	Sulfur dioxide
Asbestos	Hydrochloric acid	Sulfuric acid
Bacteria or viruses	Hydrofluoric acid	Suspect or known carcinogens
Benzene	Lead	TDI
Beryllium	Lindane	Toluene
Boron trichloride	Mercury	Toluene disocyanate
Carbon Disulfide	Methanol	Toxaphenes
Carbon Monoxide	Methyl bromide	Trichloroethane
Chlorates	Methyl ethers	Trichloroethylene
Chlorinated hydrocarbons	Methyl chlorides	Vibrating tools
Chlorine	Nitric acid	Vinyl chloride
Chlorosilanes (electronic wafers)	Nitrogen oxides (burning plastics)	Xylene
Coke oven emissions	Organic peroxides (Methyl-ethyl ketone peroxide or MEK-benzoyl peroxide)	Other:
Cyanide	PCB's	
Ethylene glycol	Pesticides	