



Clallam County Fire District #5
Report of Physical Examination for Membership
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Name (Last, First, and Middle Initial)		Birth Date		Social Security No.	
Mailing Address (Include Apartment Number, if any)				Home Telephone (Include Area Code)	
City	County	State	Zip	Work (or Message) Telephone	

HEALTH HISTORY (To be completed by applicant)

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease or heart attack; or other cardiovascular condition. <input type="checkbox"/> Medication	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease, emphysema, asthma, chronic bronchitis.
<input type="checkbox"/>	<input type="checkbox"/>	Head/Brain injuries, disorders or illnesses.	<input type="checkbox"/>	<input type="checkbox"/>	Chronic back pain.
<input type="checkbox"/>	<input type="checkbox"/>	Seizures, Epilepsy. <input type="checkbox"/> Medication	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease, dialysis.
<input type="checkbox"/>	<input type="checkbox"/>	Ear disorder, loss of hearing or balance.	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease.
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath.	<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems.
<input type="checkbox"/>	<input type="checkbox"/>	Loss of or altered consciousness.	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or elevated blood sugar controlled by: <input type="checkbox"/> Diet
<input type="checkbox"/>	<input type="checkbox"/>	Stroke or paralysis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Pills
<input type="checkbox"/>	<input type="checkbox"/>	Fainting, dizziness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Insulin
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure. <input type="checkbox"/> Medication	<input type="checkbox"/>	<input type="checkbox"/>	Nervous or psychiatric disorders. <input type="checkbox"/> Medication
<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Spinal injury or disease.
<input type="checkbox"/>	<input type="checkbox"/>	Eye disorders or impaired vision (except corrective lenses).	<input type="checkbox"/>	<input type="checkbox"/>	Narcotic or habit-forming drug use.
<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery (valve replacement/bypass, angioplasty, pacemaker).	<input type="checkbox"/>	<input type="checkbox"/>	Missing or impaired hand, arm, foot, leg, finger, toe.
<input type="checkbox"/>	<input type="checkbox"/>	Regular, frequent alcohol use.	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorders, daytime sleepiness
<input type="checkbox"/>	<input type="checkbox"/>	Regular use of a controlled substance.	<input type="checkbox"/>	<input type="checkbox"/>	Any illness or injury in the last 5 years that required hospitalization?
<input type="checkbox"/>	<input type="checkbox"/>	Regular, chemical substance use which may impair or limit your ability or skill.	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia

I hereby certify the above answers are full, complete and true to the best of my knowledge.

Applicant to sign in presence of examiner

PHYSICAL EXAMINATION

Blood Pressure _____		Circle One		Regular	Irregular
Pulse Rate _____		Weight	BMI		
Height _____					
Yes	No	Body System	Check For		
<input type="checkbox"/>	<input type="checkbox"/>	General Appearance	Markedly overweight, tremor, signs of alcoholism, problem drinking or drug abuse.		
<input type="checkbox"/>	<input type="checkbox"/>	Eyes	Pupillary equality, reaction to light.		
<input type="checkbox"/>	<input type="checkbox"/>	Ears	Middle ear disease, occlusion of external canal, perforated eardrums.		
<input type="checkbox"/>	<input type="checkbox"/>	Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing.		
<input type="checkbox"/>	<input type="checkbox"/>	Heart	Murmurs, extra sounds, enlarged heart, pacemaker.		
<input type="checkbox"/>	<input type="checkbox"/>	Lungs	Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rates, impaired respiratory function, dyspnea, cyanosis.		
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen and viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness.		

<input type="checkbox"/>	<input type="checkbox"/>	Vascular system	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.
<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary System	Hernias.
<input type="checkbox"/>	<input type="checkbox"/>	Extremities	Loss or impairment of leg, foot, toe, arm hand finger. Perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain grip. Insufficient mobility and strength in lower limbs to lift and move patients, and/or fire department equipment.
<input type="checkbox"/>	<input type="checkbox"/>	Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.
<input type="checkbox"/>	<input type="checkbox"/>	Neurological	Impaired equilibrium, coordination or speech pattern, paresthesia, asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia.
Comments _____			
Urinalysis			
Sp. Gr.	Protein	Blood Sugar	UTox
Practitioner Opinion			
<input type="checkbox"/> Capable of sustained arduous duty		<input type="checkbox"/> Capable of modified duty	
Practitioner remarks or recommendations			
Date of Examination _____		Practitioner's Signature _____	

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