MEDICAL SURVEILLANCE PROGRAM

PENNSYLVANIA STATE POLICE FIRE MARSHAL UNIT

I. Personal Information and Medical History

A comprehensive history is an important part of your medical record. Please complete this **confidential** questionnaire placing a check mark (√) in the appropriate spaces or **printing** other information where requested. (Use black or blue ink)

1. *IDENTIFICATION* Today's Date _____

Sex: [ ] Male [ ] Female

Check One: [ ] Black (non-Hispanic) [ ] Hispanic [ ] White (non-Hispanic) [ ] Asian/Pacific Islander [ ] American Indian/Alaskan Native

LAST NAME FIRST (No nicknames) MIDDLE

SOCIAL SECURITY NO. BIRTHDATE PLACE OF BIRTH: Country State City

RANK TROOP / STATION WORK TELEPHONE NO.

WORK ADDRESS CITY, STATE

HOME MAILING ADDRESS *(OPTIONAL)* CITY, STATE ZIP HOME TELEPHONE NO.

2. *MEDICATIONS*

List ALL medications (including prescription, non-prescription, vitamins and herbal preparations) you currently take:

3. *SOCIAL HISTORY*

Have you ever used tobacco? [ ]Yes [ ]No

If "yes", When: [ ] Current [ ] Past - years since quitting? _____

Type: [ ] Cigarettes [ ] Pipe/Cigar [ ] Snuff/Chewing

Amount per day? _____ For how many years? _____

What is your average alcohol consumption in a week? _____ drinks

(1 drink = 12 oz. beer, 1 glass wine or 1.5 oz liquor)

How often do you drink alcohol? [ ] Weekdays [ ] Weekends [ ] Both

4. *FAMILY HISTORY*

1. Father ☐ Alive ☐ Deceased	Current age	General health now ☐Excellent ☐Good ☐Fair ☐Poor ☐Unkn	Age & cause of death or reason for poor health
2. Mother ☐ Alive ☐ Deceased	Current age	General health now ☐Excellent ☐Good ☐Fair ☐Poor ☐Unkn	Age & cause of death or reason for poor health
3. Number of brothers	Age range	Health problems, if any	Age & cause of death or reason for poor health
4. Number of sisters	Age range	Health problems, if any	Age & cause of death or reason for poor health

5. Familial Diseases - Have any of your blood relatives had any of the following (ONLY) grandparents, parents, siblings)

☐Stroke	☐Heart Attacks	☐Herpes
☐Cancer	☐Heart Operations	☐Anemia
☐Emphysema	☐Elevated Cholesterol	☐Glaucoma
☐Bleeding Tendencies	☐Asthma	☐Arthritis
☐Diabetes	☐Hay Fever	☐Colitis
☐Epilepsy	☐Nervous Breakdown	☐Tuberculosis
☐Thyroid Disorder	☐Gout	☐Alcohol/Drug Abuse
☐Measles	☐Leukemia	☐Stomach Ulcers
☐Venereal Disease	☐Kidney Disease	☐Hepatitis
☐Fainting Spells	☐Mental Disorder	☐Gall Bladder Disease
☐High Blood Pressure	☐Migraine Headaches	☐Hernia
☐Heart Disease	☐Back Trouble	☐Obesity

☐Other _____

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge..

Employee's Signature: _____ **Date:** _____

5. *MEDICAL HISTORY*

Which of the following conditions have you ever had?
Enter year of diagnosis if known, or place √ if unknown.

[ ] Allergies, specify: _____
[ ] Cancer, cell type: _____ year of diagnosis: _____
[ ] Anemia
[ ] Asthma
[ ] Claustrophobia
[ ] Collapsed lung
[ ] Depression
[ ] Diabetes
[ ] Elevated lipids
[ ] Emphysema
[ ] Head injury
[ ] Heart attack
[ ] Heart murmur
[ ] Herniated disc
[ ] Hypertension
[ ] Kidney disease
[ ] Loss of consciousness
[ ] Migraines
[ ] Positive skin test for TB
[ ] Prostate problems
[ ] Ruptured ear drum
[ ] Seizures
[ ] Thyroid trouble

Other medical disorders - Specify:

Year of last tetanus booster: _____
Year of last chest x-ray: _____
Have you received Hepatitis B vaccine? [ ] Yes [ ] No
If "yes", number of shots: [ ] 1 [ ] 2 [ ] 3 Year completed: _____

6. *HOSPITALIZATIONS AND SURGERIES*

YEAR REASON

7. *PHYSICAL ACTIVITY OR EXERCISE PROGRAM*

Describe your physical activity or exercise program:

Aerobic exercise: [ ] Low [ ] Moderate [ ] High
Activities: _____
Frequency: _____ (days per week)
Duration: _____ (minutes/session)

Isometric exercise: [ ] Low [ ] Moderate [ ] High
Activities: _____
Frequency: _____ (days per week)
Duration: _____ (minutes/session)

8. *HEARING QUESTIONNAIRE*

	Yes	No
Have you had prior military service?	[ ]	[ ]
Have you had previous ear surgery?	[ ]	[ ]
Have you had recurrent ear infections?	[ ]	[ ]
Do you have a known hearing loss?	[ ]	[ ]
Have you had a recent cold or congestion?	[ ]	[ ]
Have you had noise exposure within the last 14 hrs?	[ ]	[ ]
Do you wear hearing protection?	[ ]	[ ]

If "yes", type: [ ] foam [ ] pre-molds/plugs [ ] ear muffs

9. *REVIEW OF SYSTEMS* - Which of the following have been a problem for you ***in the last year***?

General/Constitutional
- ☐ Fever, >100°
- ☐ Shivering/ chills
- ☐ Generalized weakness
- ☐ Unexplained weight loss/gain
- ☐ Excessive fatigue
- ☐ Swollen glands
- ☐ Loss of appetite

Eyes
- ☐ Change in vision
- ☐ Itching
- ☐ Tearing

Ears, Nose, Throat
- ☐ Difficulty hearing
- ☐ Ringing, buzzing
- ☐ Sinus trouble
- ☐ Sneezing/runny nose
- ☐ Nosebleeds
- ☐ Difficulty swallowing

Heart/Lungs
- ☐ Chest pain or pressure
- ☐ Irregular heart beat
- ☐ Palpitations/skipped beats
- ☐ New or changed cough
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Shortness of breath

Digestive System
- ☐ Nausea/vomiting
- ☐ Diarrhea/constipation *(circle one or both)*
- ☐ Yellow jaundice
- ☐ Rectal bleeding or black tarry stools

Neurologic/Psychiatric
- ☐ Headaches
- ☐ Dizziness/passing out *(circle one or both)*
- ☐ Depression
- ☐ Numbness or tingling
- ☐ Excessive anxiety
- ☐ Insomnia/difficulty sleeping
- ☐ Loss of memory

Skin/Musculoskeletal
- ☐ Rashes
- ☐ Moles that changed in size or color
- ☐ Muscle pain
- ☐ Back pain
- ☐ Neck pain
- ☐ Weakness in arms/legs
- ☐ Joint pain

Genitourinary & Reproductive
- ☐ Difficult or painful urination
- ☐ Blood in urine
- ☐ Difficulty having children

(Men Only)
- ☐ Lump in Testicle
- ☐ Impotence

(Women Only)
- ☐ Irregular periods/spotting
- ☐ Miscarriage or stillborn pregnancy
- ☐ Breast lump/discharge
- ☐ Currently or possibly pregnant

Examiner's comments: [All positive responses by employee on pages 1-2 should be clarified.]

NOTE: PAGES 4 AND 5 ARE TO BE COMPLETED BY EXAMINING PHYSICIAN

II. Physical Examination

10. PHYSICAL EXAMINATION:

Vital Signs: _____ in _____ lb _____ / _____ mm/Hg _____

Height Weight Blood Pressure Pulse

Tonometry: O.D.____ O.S.____ *PPD:* ☐ Not done ☐ Mantoux: _____ mm. Induration *Stool for Occult Blood:* ☐ Not done ☐ Positive ☐ Negative x 3

	Normal	Abnormal	Not Done	Comments:
General	[ ]	[ ]	[ ]	
Skin	[ ]	[ ]	[ ]	
Head	[ ]	[ ]	[ ]	
Eyes	[ ]	[ ]	[ ]	
Ears	[ ]	[ ]	[ ]	
Nose	[ ]	[ ]	[ ]	
Mouth	[ ]	[ ]	[ ]	
Throat	[ ]	[ ]	[ ]	
Neck	[ ]	[ ]	[ ]	
Thyroid	[ ]	[ ]	[ ]	
Lymph Nodes	[ ]	[ ]	[ ]	
Lungs	[ ]	[ ]	[ ]	
Breasts	[ ]	[ ]	[ ]	
Heart	[ ]	[ ]	[ ]	
Abdomen	[ ]	[ ]	[ ]	
Genitalia	[ ]	[ ]	[ ]	
Rectal	[ ]	[ ]	[ ]	
Extremities	[ ]	[ ]	[ ]	
Arterial Pulses	[ ]	[ ]	[ ]	
Musculoskeletal	[ ]	[ ]	[ ]	
Neurologic	[ ]	[ ]	[ ]	
Mental Status	[ ]	[ ]	[ ]	

11. INTERPRETATION OF LAB AND OTHER SCREENING RESULTS:

	Normal	-----Abnormal----- Clinically Insignificant	Clinically Significant	Not Done
Chem Profile				
Liver function	[ ]	[ ]	[ ]	[ ]
Renal function	[ ]	[ ]	[ ]	[ ]
Other chemistries	[ ]	[ ]	[ ]	[ ]
CBC	[ ]	[ ]	[ ]	[ ]
Urinalysis	[ ]	[ ]	[ ]	[ ]
ZPP	[ ]	[ ]	[ ]	[ ]
Lead (serum)	[ ]	[ ]	[ ]	[ ]
Heavy metal screen	[ ]	[ ]	[ ]	[ ]
Plasma Cholinesterase	[ ]	[ ]	[ ]	[ ]
RBC Cholinesterase	[ ]	[ ]	[ ]	[ ]
PCBs	[ ]	[ ]	[ ]	[ ]
Stool for Occult Blood	[ ]	[ ]	[ ]	[ ]

	Normal	-----Abnormal----- Clinically Insignificant	Clinically Significant	Not Done
Audiometry	[ ]	[ ]	[ ]	[ ]
Chest x-ray	[ ]	[ ]	[ ]	[ ]
B-reading	[ ]	[ ]	[ ]	[ ]
EKG	[ ]	[ ]	[ ]	[ ]
PPD (Mantoux)	[ ]	[ ]	[ ]	[ ]
Spirometry	[ ]	[ ]	[ ]	[ ]
Tonometry	[ ]	[ ]	[ ]	[ ]
Visual Acuity	[ ]	[ ]	[ ]	[ ]
Urine Cytology	[ ]	[ ]	[ ]	[ ]
NMP-22	[ ]	[ ]	[ ]	[ ]
Other _____	[ ]	[ ]	[ ]	[ ]
_____	[ ]	[ ]	[ ]	[ ]

Comments:

MEDICAL SURVEILLANCE PROGRAM
III. Summary

12. ASSESSMENT / REFERRAL PLAN:

	Comments:	Not Referred	--Referred--- Routine	Urgent
1._____	_____	[ ]	[ ]	[ ]
2._____	_____	[ ]	[ ]	[ ]
3._____	_____	[ ]	[ ]	[ ]
4._____	_____	[ ]	[ ]	[ ]
5._____	_____	[ ]	[ ]	[ ]

_____ Examiner (print)

_____ Examiner's signature

_____ Date

I have received a copy of the summary of my examination and understand the recommendations:

_____ Employee's Signature

_____ Date