El Camino College

FIRE ACADEMY

PHYSICAL EXAMINATION FORM

(To Be Completed By The Physician)

APPLICANT'S NAME ______________________________ DATE OF EXAM ____________

AGE ________ WEIGHT ____________ HEIGHT ____________ RESTING PULSE RATE ____________

BLOOD PRESSURE ______________________________

COMMENTS ON APPLICANT'S HEALTH HISTORY ______________________________

____

____

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	Normal	Abnormal	Comments
HEAD			
Eyes			
Pupils			
Ocular Motion			
Ears			
Nasal Cavity			
Mouth: Teeth			
Tongue			
Tonsils			
NECK			
Thyroid			
Cervical Nodes			
CHEST			
Lungs			
Heart: Size			
Sounds			
Resting EKG			
ABDOMEN			
GENITALIA			
MUSCULOSKELETAL			
Cervical Spine			
Thoracic Spine			
Lumbar Spine			
Shoulders			
Elbows			
Hips			
Knees			
Ankles			
Hands			
Feet			
Other Joints			
NEUROLOGICAL			
Reflexes			
SKIN			

PHYSICAL EXAMINATION FORM-MEDICAL CLEARANCE (continued)

APPLICANT'S NAME ____

I have examined the above applicant and the applicant has passed the medical examination.

I have found him/her to be medically qualified to participate in the Physical Conditioning Program at the Fire Academy through El Camino College. I have been provided with the applicant's Health History Statement. Any exercise limitations are listed below.

Exercise Limitations: ____

____

____

____

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____

EXAMINING PHYSICIAN ____
(Print Name)

Address ____
Number Street City State Zip

Medical License # ________________________________

Signature: ________________________________

Date: ________________________________

El Camino College

FIRE ACADEMY

HEALTH HISTORY STATEMENT

(To Be Completed By The Student)

The information you provide in this statement will be used to assess your medical qualifications to participate in the Academy Physical Conditioning Program. Please complete this form accurately, legibly, and completely, and present it to your physician when he performs your medical examination. All information will be kept confidential.

Name ____
(Last) (First) (Middle)

Sex ________ Height __________ Weight __________ Date of Birth __________ Today's Date __________

Home Address ____
(Number) (Street) (Apt. #)

City ______________________________ State ______________ Zip ______________

Home Phone ( ) ______________________ Business or Message Phone ( ) ______________________

Date of Last Medical Examination ____

Characterize your present health status (check one): Excellent ☐ Good ☐ Fair ☐ Poor ☐

Have you ever smoked cigareetes, cigars, or a pipe? ____

How many cigarettes per day? __________ Cigars per day? __________ Pipefuls per day? __________

What are your present smoking habits? ____

Do you drink alcoholic beverages? __________ If yes, what is your approximate intake?
Beer: ______ per week Wine: ______ per week Hard Liquor: ______ per week

List any traumatic injuries you have experienced to your bones or soft tissue, (include any disabling back problems), and the approximate date of the injury.

______________________________ Date: ______________
______________________________ Date: ______________
______________________________ Date: ______________

List any operations you have had, and the approximate date.

______________________________ Date: ______________
______________________________ Date: ______________
______________________________ Date: ______________

List any illnesses you have had which required you to take more than one week of sick leave.

______________________________ Date: ______________
______________________________ Date: ______________
______________________________ Date: ______________

List any other significant health conditions.

______________________________ Date: ______________
______________________________ Date: ______________

List any medications you are now taking. Include self-prescribed medications and dietary supplements.

Type of medication: ____________ Dosage: ____________ Frequency: ____________
Purpose: ____________
Type of medication: ____________ Dosage: ____________ Frequency: ____________
Purpose: ____________

List any athletic or physical activities that you regularly engage in. Specify for each the frequency, intensity, and duration of your involvement, as in the example.

ACTIVITY	FREQUENCY	INTENSITY	DURATION
(Example) Bycycling	3 times per week	10 miles	past 18 months

DIET AND WEIGHT

What is your present weight? ____________ What is a good weight for you? ____________

What is the most you have ever weighed? ____________ How long ago? ____________

Is your present weight stable? ____________

Do you have trouble keeping your weight stable? ____________

Are you presently dieting? ________ If so, describe: ____________

How many times per week do you eat the following: Vegetables: ______ Fruits: ______ Eggs: ______
Beef: ____ Pork: ____ Fish: ____ Fowl: ____ Fried Foods: ____ Deserts: ____

How much and how often do you consume: Milk? ____________
Coffee? ____________ Tea? ____________ Cola? ____________

MEDICAL HISTORY

Do you now have or have you ever had any of the following?

YES	NO		YES	NO		YES	NO	
		Allergies			Arthritis			Asthma
		Chronic Bronchitis			Diabetes Mellitus			Emphysema
		Heart Disease			High Blood Pressure			Heart Murmur
		Stroke			Obesity			Neurological Problems
		Musculoskeletal Problems			High Serum Lipids (Fats--for example, cholesterol)			

Have you ever experienced any of the following? For each condition checked, indicate whether the condition was diagnosed and whether the condition was associated with exercise or physical work.

Experienced? yes	Experienced? no		Diagnosed? yes	Diagnosed? no	Exercise or Physical Work? yes	Exercise or Physical Work? no
		Chest Pain				
		Chest Pressure				
		Discomfort or Pain in Elbow				
		Discomfort or Pain in Jaw				
		Discomfort or Pain in Teeth				
		Discomfort or Pain in Throat				
		Discomfort or Pain in Wrist				
		Heart Palpitations or Skipped Beats				

Have you ever taken any of the following tests? If yes, indicate whether the results indicated any abnormalities.

yes	no			yes	no
		Exercise Stress Test	Any Abnormalities?		
		Exercise Stress Test with Isotopes	Any Abnormalities?		
		Echocardiogram	Any Abnormalities?		
		Coronary Angiogram	Any Abnormalities?		
		Holter Monitor	Any Abnormalities?		

Has a blood relative ever been diagnosed as having any of the following? (Include parents, grandparents, aunts, uncles, brothers, sisters, and children, but exclude relatives by marriage.)

yes	no		MOTHER	FATHER	OTHER
		Diabetes Mellitus			
		Heart Disease			
		High Blood Pressure			
		High Serum Lipids (Fats, Cholesterol)			
		Obesity			
		Stroke			

List anything else which you feel may be important in your medical history, including any conditions not specifically referred to in the proceeding questions.

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Signature: ______________________________ Date: ______________