HEARTFIT FOR DUTY

Name:_____

Protecting our First Responders

CONSENT TO TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I agree to the retrieval of all immunization records and continued monitoring of my need for further immunizations.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient: _____

Printed Name of patient: _____

Date: _____

CONSENT TO MEDICAL PHOTOGRAPHY

Patient Name: _____ DOB: _____

Your doctor has determined that it is necessary or helpful to obtain a photograph of your skin condition to assist with treatment. This form will be part of your medical record and will be held and used strictly in accordance with your wishes which can be defined below. Photographs will only be taken and used with your consent, which can be refused or limited by you and you can also withdraw this or change it in the future. You will have the opportunity to view all images.

Please circle one

I consent to photographs being taken for my medical records.	☐ Yes ☐ No
I consent to the photographs being made available to other clinicians involved in my treatment.	☐ Yes ☐ No
I consent to my photographs being used for teaching purposes providing that these are kept anonymous.	☐ Yes ☐ No
I consent to my photographs being used for my Occupational Physical Exam and or Primary Care.	☐ Yes ☐ No

I require the following restrictions to be applied to my image.

(Patient signature):_____ Date: _____

(Parent/Guardian Signature):_____ Date: _____

Name of Clinician: _____

Cancer Screening Questionnaire

Personal Cancer Screening History

Use the Table Below to record your screening history. Depending on your age and other factors, you may not have experience with some, or all of the screenings listed. Regardless of screening history, it is important to be aware and in touch with changes your body is experiencing. Talk to your doctor about which screenings are right for you.

Type of Cancer	Screening Tests	Most Recent	How Often	Age Started	Comments
FOR WOMEN					
Breast	Clinical Breast Exam				
	Mammogram				
Cervical	PAP Smear				
	Pelvic Exam				
FOR MEN					
Prostate	Digital Rectal Exam				
	PSA Blood Test				
FOR MEN & WOMEN					
Colorectal	Colonoscopy				
	Sigmoidoscopy				
	At home stool test				
	Other				

If you have ever been diagnosed with cancer, please fill in the chart below with as much information as you know.

Type of Cancer	Age at Diagnosis	Comments
Ex: Breast	50	Estrogen positive cancer, remission 5 years
Uterine		
Ovarian		
Colorectal		
Breast		
Prostate		
Cervical		
Other		

Personal Symptoms

If you are experiencing any of the conditions below, it is important to share them with your doctor. Select any symptoms

you have and capture any additional information in the comments column.

Yes	No	Condition	Comments
FOR MEN & WOMEN			
☐	☐	**A change in bowel habits, ex: Diarrhea, constipation, or narrowing of the stool that lasts more than a few days**	
☐	☐	**Rectal bleeding**	
☐	☐	**Dark stool, or Bloody stool**	
☐	☐	**Cramping or Abdominal pain**	
☐	☐	**Weight Loss**	
☐	☐	**Fatigue, lack of energy**	
☐	☐	**New back pain**	
☐	☐	**Changes in appearance of one of both nipples**	

☐	☐	**Nipple discharge**	
☐	☐	**General pain in/on any part of breast**	
☐	☐	**Irritated or Itchy breasts**	
☐	☐	**Change in breast color, size, shape, or touch**	
☐	☐	**Peeling or flaking of the nipple**	
☐	☐	**Skin**	
FOR WOMEN			
☐	☐	**Vaginal Bleeding**	
☐	☐	**Unusual vaginal discharge or odor**	
☐	☐	**Pelvic pain**	

Family Cancer History

When it comes to cancer, knowing your family history is important. Find out all you can about your Whole family. Don't just stop at parents and siblings. It's also important to know which side of your family the relative is on. Fill out the chart below with as much detail as you can.

Type of Cancer	Relation	Age at Diagnosis	Age at Death	Comments
Example: Breast	Aunt on Mother's side	50	59	
Uterine				
Ovarian				
Colorectal				
Breast				
Prostate				
Cervical				
Other				

AUDIOMETRY QUESTIONNAIRE

TO BE COMPLETED BY EMPLOYEE
CURRENT DETAILS

Name:	
Date of Birth:	**Employer:**
Job Title:	**Department:**
Contact Number:	**Length of employment:**

OCCUPATIONAL HISTORY:
Give details of any previous employment in which you were exposed to noise. How long did you work for the company? Was hearing protection provided?

RELEVANT MEDICAL HISTORY Please give details below if **YES** to any questions.

1. Do you wear a hearing aid?	☐ Yes	☐ No
2. Do you have any trouble with your hearing?	☐ Yes	☐ No
3. Have you ever attended your doctor with ear problems or hearing difficulties?	☐ Yes	☐ No
4. Have you ever had a serious head injury?	☐ Yes	☐ No
5. Do you suffer from vertigo or dizziness?	☐ Yes	☐ No
6. Is there any deafness in your family?	☐ Yes	☐ No
7. Do you suffer from noises or ringing in the ears?	☐ Yes	☐ No
8. Have you had a recent cold or nasal congestion?	☐ Yes	☐ No
9. Have you had measles / mumps/meningitis/scarlet fever?	☐ Yes	☐ No
10. Are you on any medication?	☐ Yes	☐ No

OTHER RELEVANT INFORMATION

1. Have you had regular exposure to gunfire or explosions?	☐ Yes	☐ No
2. Are you exposed to any activities/hobbies out of work that involve loud noises?	☐ Yes	☐ No
3. Have you had a previous hearing test?	☐ Yes	☐ No
4. If you have had a previous hearing test, have any issues been identified?	☐ Yes	☐ No

HEARTFIT FOR DUTY

Name:_____

Protecting our First Responders

CURRENT HEARING PROTECTION

1. Do you work in an area designated for the use of hearing protection? ☐ Never ☐ Occasionally ☐ Frequently ☐ Always

2. Have you been issued hearing protection? ☐ Yes ☐ No

3. Have you been instructed in the use of and maintenance of your hearing protection? ☐ Yes ☐ No

4. What type of hearing protection have you been issued with? ☐ Headphones ☐ Earplugs ☐ Other

5. Do you use hearing protection in designated hearing protection areas? ☐ Never ☐ Occasionally ☐ Frequently ☐ Always

6. Do you suffer from noises or ringing in the ears? ☐ Never ☐ Occasionally ☐ Frequently ☐ Always

7. Have you been working in a noisy environment in the last 48 hours? ☐ Yes ☐ No

Comments: _____

_____

_____

_____

PATIENT SIGNATURE: _____ **DATE:** _____

HEARTFIT FOR DUTY

Name:_____

Protecting our First Responders

Date: _____

Personal Information:		
Last Name:	First Name:	M.I.:
Address:		
City:	State:	Zip:
Phone:	D.O.B.:	Age:
Email:		
Gender: ☐ Male ☐ Female		

Employer Information	
Employer:	Hire Date:
Employment Status (FT, PT, Volunteer): ☐ FT ☐ PT ☐ Volunteer	Employer Phone: Employee ID #:
Rank/Title:	

Emergency Notification Contact Information		
Name:		
Relationship:		
Contact Phone 1:	Contact Phone 2:	
Address:		
City:	State:	Zip:

Primary Care Physician Information		
Primary Care Physician/Group:		
Phone:	Fax:	
Office Address:		
City:	State:	Zip:

1. Would you like to talk to the healthcare professional who will review this questionnaire, about your answers to this questionnaire: ☐ Yes ☐ No

2. A phone number where you can be reached by the healthcare professional, who reviews the questionnaire: _____

3. The best time to reach you at this number: _____

4. Do you currently smoke tobacco, or have you smoked tobacco in the last month: ☐ Yes ☐ No

5. Have you ever had any of the following conditions?

a. Seizures: ☐ Yes ☐ No

b. Diabetes (sugar disease): ☐ Yes ☐ No

c. Allergic reactions that interfere with your breathing: ☐ Yes ☐ No

d. Claustrophobia (fear of closed-in places): ☐ Yes ☐ No

e. Trouble smelling odors: ☐ Yes ☐ No

6. Have you ever had any of the following pulmonary or lung problems?

a. Asbestosis: ☐ Yes ☐ No

b. Asthma: ☐ Yes ☐ No

c. Chronic bronchitis: ☐ Yes ☐ No

d. Emphysema: ☐ Yes ☐ No

e. Pneumonia: ☐ Yes ☐ No

f. Tuberculosis: ☐ Yes ☐ No

g. Silicosis: ☐ Yes ☐ No

h. Pneumothorax (collapsed lung): ☐ Yes ☐ No

i. Lung cancer: ☐ Yes ☐ No

j. Broken ribs: ☐ Yes ☐ No

k. Any chest injuries or surgeries: ☐ Yes ☐ No

l. Any other lung problem that you've been told about: ☐ Yes ☐ No

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

a. Shortness of breath: ☐ Yes ☐ No

b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: ☐ Yes ☐ No

c. Shortness of breath when walking with other people at an ordinary pace on level ground: ☐ Yes ☐ No

d. Have to stop for breath when walking at your own pace on level ground: ☐ Yes ☐ No

e. Shortness of breath when washing or dressing yourself: ☐ Yes ☐ No

f. Shortness of breath that interferes with your job: ☐ Yes ☐ No

g. Coughing that produces phlegm (thick sputum): ☐ Yes ☐ No

h. Coughing that wakes you early in the morning: ☐ Yes ☐ No

i. Coughing that occurs mostly when you are lying down: ☐ Yes ☐ No

j. Coughing up blood in the last month: ☐ Yes ☐ No

k. Wheezing: ☐ Yes ☐ No

l. Wheezing that interferes with your job: ☐ Yes ☐ No

m. Chest pain when you breathe deeply: ☐ Yes ☐ No

n. Any other symptoms that you think may be related to lung problems: ☐ Yes ☐ No

8. Have you ever had any of the following cardiovascular or heart problems?

a. Heart attack:	☐ Yes	☐ No	e. Swelling in your legs or feet (not caused by walking):	☐ Yes	☐ No
b. Stroke:	☐ Yes	☐ No	f. Heart arrhythmia (heart beating irregularly):	☐ Yes	☐ No
c. Angina:	☐ Yes	☐ No	g. High blood pressure:	☐ Yes	☐ No
d. Heart failure:	☐ Yes	☐ No	h. Any other heart problem that you've been told about:	☐ Yes	☐ No

Questions 9 to 14 below must be answered by every employee who has been selected to use either a full facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

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

a. Frequent pain or tightness in your chest:	☐ Yes	☐ No
b. Pain or tightness in your chest during physical activity:	☐ Yes	☐ No
c. Pain or tightness in your chest that interferes with your job:	☐ Yes	☐ No
d. In the past two years, have you noticed your heart skipping or missing a beat:	☐ Yes	☐ No
e. Heartburn or indigestion that is not related to eating:	☐ Yes	☐ No
f. Any other symptoms that you think may be related to heart or circulation problems:	☐ Yes	☐ No

10. Do you currently take medication for any of the following problems?

a. Breathing or lung problems:	☐ Yes	☐ No
b. Heart trouble:	☐ Yes	☐ No
c. Blood pressure:	☐ Yes	☐ No
d. Seizures:	☐ Yes	☐ No

11. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9).

a. Eye irritation:	☐ Yes	☐ No
b. Skin allergies or rashes:	☐ Yes	☐ No
c. Anxiety:	☐ Yes	☐ No
d. General weakness or fatigue:	☐ Yes	☐ No
e. Any other problem that interferes with your use of a respirator:	☐ Yes	☐ No

12. Have you ever lost vision in either eye (temporarily or permanently): ☐ Yes ☐ No

13. Do you currently have any of the following vision problems?

a. Wear contact lenses:	☐ Yes	☐ No
b. Wear glasses:	☐ Yes	☐ No
c. Color blind:	☐ Yes	☐ No
d. Any other eye or vision problem:	☐ Yes	☐ No

14. Have you ever had an injury to your ears, including a broken ear drum: ☐ Yes ☐ No

15. Do you currently have any of the following hearing problems?

a. Difficulty hearing: ☐ Yes ☐ No

b. Wear a hearing aid: ☐ Yes ☐ No

c. Any other hearing or ear problem: ☐ Yes ☐ No

16. Have you ever had a back injury: ☐ Yes ☐ No

17. Do you currently have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet: ☐ Yes ☐ No

b. Back pain: ☐ Yes ☐ No

c. Difficulty fully moving your arms and legs: ☐ Yes ☐ No

d. Pain or stiffness when you lean forward or backward at the waist: ☐ Yes ☐ No

e. Difficulty fully moving your head up or down: ☐ Yes ☐ No

f. Difficulty fully moving your head side to side: ☐ Yes ☐ No

g. Difficulty bending at your knees: ☐ Yes ☐ No

h. Difficulty squatting to the ground: ☐ Yes ☐ No

i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: ☐ Yes ☐ No

j. Any other muscle or skeletal problem that interferes with using a respirator: ☐ Yes ☐ No

18. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: ☐ Yes ☐ No

a. If "yes," name the chemicals if you know them: _____

19. Have you ever worked with any of the materials, or under any of the conditions, listed below:

a. Asbestos: ☐ Yes ☐ No

b. Silica (e.g., in sandblasting): ☐ Yes ☐ No

c. Tungsten/cobalt (e.g., grinding or welding this material): ☐ Yes ☐ No

d. Beryllium: ☐ Yes ☐ No

e. Aluminum: ☐ Yes ☐ No

f. Coal (e.g., mining): ☐ Yes ☐ No

g. Iron: ☐ Yes ☐ No

h. Tin: ☐ Yes ☐ No

i. Dusty environments: ☐ Yes ☐ No

j. Any other hazardous exposures: ☐ Yes ☐ No

i. If "yes" answered to any of the above, describe the exposure(s): _____

20. List any second jobs or side businesses you have: _____

21. List your previous occupations: _____

22. List your current and previous hobbies: _____

23. Have you been in the military services? ☐ Yes ☐ No

a. If "yes," were you exposed to biological or chemical agents (either in training or combat): ☐ Yes ☐ No

24. Have you ever worked on a HAZMAT team? ☐ Yes ☐ No

25. Alcohol Use: ☐ Yes ☐ No

a. How many beers do you drink each week? _____

b. How many bottles of wine per week? _____

c. How many drinks of liquor per week? _____

26. Tobacco Current Use:

a. Do you currently use tobacco? ☐ Yes ☐ No

b. How many of the following did you smoke or chew per day?

i. Cigarettes _____ Packs/day _____ x years

ii. Chew _____ Cans/day _____ x years

27. Tobacco Past Use:

a. Have you used tobacco in the past? ☐ Yes ☐ No

b. How many of the following did you smoke or chew per day?

i. Cigarettes _____ Packs/day _____ x years

ii. Chew _____ Cans/day _____ x years

iii. Quit Date: _____

28. Fitness Review:

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

i.Aerobic _____ x/week

ii. Weight Training _____ x/week

iii. Other: _____ _____ x/week

b. Since your last exam, compare your activity level: ☐ More ☐ Less ☐ Same

29. Occupational Exposures

a. Have you had any work related exposures to fires or HazMat situations where you have developed health changes? ☐ Yes ☐ No

i. If yes, please describe: _____

b. Other Work Related Health Problems (since last exam)

i. Occupational Injuries/Illnesses: _____

ii. Diagnosis: _____

Time lost: _____

c. Are you a member of the Hazardous Materials Team? ☐ Yes ☐ No

i. If yes, have you had any exposures in the last year? ☐ Yes ☐ No

d. Are you a member of the FEMA (AZ Task Force-1) team? ☐ Yes ☐ No

i. If yes, have you been on a deployment in the last year? ☐ Yes ☐ No

30. Recreational / Hobbies Review: ☐ Yes ☐ No

a. Are you finding your hobbies and recreation less enjoyable? ☐ Yes ☐ No

b. Do you feel fatigued even if you have not been physically active? ☐ Yes ☐ No

c. Are you worrying more than usual? ☐ Yes ☐ No

d. Are you more irritable than usual around family or co-workers? ☐ Yes ☐ No

e. List your hobbies (i.e. woodworking, stained glass, etc.) and number of times per week you perform them: ☐ Yes ☐ No

I. _____ x week: _____

II. _____ x week: _____

III. _____ x week: _____

IV. _____ x week: _____

f. Do you use any chemicals or other materials in your hobbies such as solvents, solder, pesticides, lead, or other materials? ☐ Yes ☐ No

i. If yes, please describe chemicals involved: _____

31. Medication Review:

a. Are you currently taking, or have you taken any of the following within the past month?

- ☐ Antacids
- ☐ Antibiotics
- ☐ Anticoagulants (blood thinners)
- ☐ Antidepressants
- ☐ Antihistamines
- ☐ Anti-inflammatory
- ☐ Appetite suppressants
- ☐ Aspirin
- ☐ Blood pressure pills
- ☐ Codeine
- ☐ Cortisone or Steroids
- ☐ Digitalis
- ☐ Diuretic (water pills)
- ☐ Hormones
- ☐ Insulin/oral diabetic drug
- ☐ Laxatives
- ☐ Sleeping pills
- ☐ Testosterone/Anabolic Steroid
- ☐ Thyroid
- ☐ Tranquilizers
- ☐ Tylenol
- ☐ Vitamins/Supplements

b. List any drugs (by name) you take regularly and the dosage used:

_____

32. Since your last exam, have you developed any allergies? ☐ Yes ☐No

a. If yes, please describe: _____

33. Since your last exam, have you had any difficulties having children? (i.e. infertility, miscarriage, spontaneous abortion) ☐ Yes ☐ No ☐N/A

a. If yes, please describe: _____

34. Since your last exam, have you had any health changes or problems? ☐ Yes ☐No

a. If yes, please describe: _____

35. Since your last exam, have you been hospitalized? ☐ Yes ☐No

a. If yes, please describe: _____

36. Since your last exam, have you had any surgery(s)? ☐ Yes ☐No

a. If yes, please describe
(give dates and reasons): _____