Print Form

Please print double sided if possible

Health Center

Annual 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!

150 S. 12th St., Phoenix, AZ 85034 • Phone: 602-495-5797 • Fax: 602-534-1290
Revised: 08/12/2011

Phoenix Fire Department Health Center

Annual Patient Health Review

Today's Date: ____/____/____

Personal Information:

Legal Name:

Last:_____ First:_____ M.I._____

Nickname:_____ Last four digits SSN: _____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Pager:_____ Cell:_____

D.O.B. ____/____/____ Marital Status:_____

Employer Information:

City of:_____ Hire date: ____/____/____

Employer Phone: _____

Department/Station: _____ Rank/Title:_____

Shift: _____ Employee I.D.#:_____**(*City of Phoenix only*)**

Retirement Date: ____/____/_____ *(if applicable)*

Only complete this section if there have been changes since last exam*

Emergency Notification Information

In case of emergency notify: _____

Relationship:_____ Phone number:_____

Address:_____

City:_____ State:_____ Zip:_____

Primary Care Physician Information:

Primary Care Physician:_____

Physician Office Address: _____

City:_____ State:_____ Zip:_____

Phone: _____

	YES	NO
Since your last exam, have you had any health issue changes or problems?	☐	☐

If ***yes***, please explain: _____

_____

_____

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YES NO

Since your last exam, have you been **hospitalized**?

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

Date(s):_____Reason:_____

_____

YES NO

Since your last exam, have you had any **surgery(s)**?

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

Date(s):_____Reason:_____

_____

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	☐	☐

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: _____

_____

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

Occupational Exposures:

YES	NO
☐	☐

Have you had any work related exposures to fires or HazMat situations where you have developed health changes?

If ***yes***, please describe:_____

_____

Other Work Related Health Problems (since last exam)

Occupational Injuries/Illnesses: _____

Diagnosis: _____Time Lost:_____

YES	NO
☐	☐
☐	☐
☐	☐
☐	☐

Are you a member of the **Hazardous Materials Team**?

If ***yes***, have you had any exposures in the last year?

Are you a member of the **FEMA (AZ Task Force-1)** team?

If ***yes***, have you been on a deployment in the last year?

Recreational / Hobbies Review:

	YES	NO
Are you finding your hobbies and recreation less enjoyable?	☐	☐
Do you feel fatigued even if you have not been physically active?	☐	☐
Are you worrying more than usual?	☐	☐
Are you more irritable than usual around family or co-workers?	☐	☐

List your hobbies (i.e. woodworking, stained glass, etc) and number of times per week you perform them:

1._____x week_____

2._____x week_____

3. _____ x week_____

4._____x week_____

	YES	NO
Do you use any chemicals or other materials in your hobbies such as solvents, solder, pesticides, lead, or other materials?	☐	☐

If ***yes***, please describe chemicals involved:_____

Medication Review:

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

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

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

_____

_____

	YES	NO
Since your last exam, have you developed any allergies?	☐	☐

If ***yes***, please describe _____

	YES	NO
Since your last exam, have you had any difficulties having children? (i.e. infertility, miscarriage, spontaneous abortion)	☐	☐

If ***yes***, please describe:_____