CITY OF LAS VEGAS
HEALTH HISTORY FORM

To the FireFighter: Please complete this form prior to your examination and present the completed form to the medical examiner. If the same examiner conducts both heart and lung examinations in any one year, only one History form need to be completed.

Name (Last, First, Middle) _____ Age _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____ *Organization/Employer -* ***Las Vegas Fire & Rescue***

Personal Physician's Name _____ Occupation: _____

1. Have you ever had heart trouble or ever been told that you had trouble with your heart?

2. Have you ever been treated for high blood pressure or ever been told that your blood pressure was not normal?

3. In the past five years, have you been hospitalized overnight for any reason?

4. In the last twelve months, have you seen a doctor for anything other than routine checkup?

5. Have you ever been treated for or told you have a disease of the lungs?

6. Do you smoke of use smokeless tobacco?

7. Have you experienced prolonged shortness of breath?

8. Do you have persistent cough of regular episodes of coughing?

9. Do you drink Alcoholic beverages? If yes, indicate daily quantity?

10. How many cups of coffee do you usually drink per day?

11. Have you ever had a problem with fainting, dizzy spells, or seizures?

12. Have you ever been treated for or told you had diabetes?

13. Do you have a fear of tight or enclosed places?

14. Have you ever felt sensation of smothering or inability to breath?

15. Have you ever experienced heat exhaustion or heat stroke?

16. Do you have or have you had a ruptured ear drum?

17. Do you have or have you ever been told that you have defective vision?

18. Do you wear contact lenses or eye glasses?

19. Do you have or have you been told that you have defective hearing?

20. Do you have any other condition that might interfere with the use of a respirator? (SCBA) or which could result in a limited work ability?

21. Are you taking any medications?

22. Are you being treated for or have you been told that you have a problem with allergies?

23. Have you had head or spinal injuries or surgery?

24. Do you consider yourself overweight?

25. Has any of your immediate family (siblings) ever had blood pressure trouble, and/or high blood pressure, heart trouble; heart attack; diabetes; Stroke: Gout

If you Answered Yes to any of the Health History Questions please explain on page two.

Date: _____ Signature _____

If you answered Yes to any of the previous questions, please use the following spaces to explain. Insert the item number then your response. (Example: Item # 6. Yes I smoke one or two cigarettes a day).