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Burnaby Fire Annual Health Review Form

Date:_____

Last Name: _____
First Name: _____
Address:_____
_____
Phone #:_____
E-mail: _____
Current Family Doctor: _____
Clinic Name or City: _____

Please list all prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

Do you have any allergies? If yes, identify the type below:

□ Drug/Chemical □ Food □ Environmental/Pollen □ Animal/Insect □ Other:_____

HAVE YOU EXPERIENCED ANY CHANGES TO YOUR HEALTH IN THE PAST YEAR?
Explain "Yes" answers below, and circle any questions you don't know the answers to.

	GENERAL QUESTIONS	YES	NO
1	Has a doctor denied or restricted your participation in sports, physical activity or work?		
2	Do you have any ongoing medical conditions? If yes, please identify which ones below: □ Asthma □ Anemia □ Diabetes □ Infections □ Other:_____		
3	Have you spent the night in the hospital?		
4	Have you had surgery for any reason?		
	HEART HEALTH	**YES**	**NO**
5	Have you passed out, or nearly passed out during or after exercise?		
6	Have you had discomfort, pain, tightness or pressure in your chest during exercise?		
7	Does your heart ever race or skip beats (irregular beats) during exercise?		
8	Has your doctor ever told you that you have heart problems? If so, check all that apply: □ High blood pressure □ Heart murmur □ High cholesterol □ Heart infection □ Kawasaki disease □ Other_____		
9	Has a doctor ordered a test for your heart?		
10	Do you get lightheaded or short of breath more quickly than others during exercise?		
	HEART HEALTH QUESTIONS ABOUT FAMILY	**YES**	**NO**
11	Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		

	HEART HEALTH QUESTIONS ABOUT FAMILY	YES	NO
12	Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
13	Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long or short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
14	Has anyone in your family had unexplained fainting, unexplained seizures or near drowning?		
	BONE AND JOINT QUESTIONS	**YES**	**NO**
15	Have you had an injury to a bone, muscle, ligament or tendon that caused you to miss work or sport?		
16	Have you had any broken bones or dislocated joints?		
17	Have you had an injury that required x-rays, MRI, CT, injections, therapy, a cast, a brace or crutches?		
18	Have you had a stress fracture?		
19	Do you use a brace, orthotics or other assistive devices?		

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HAVE YOU EXPERIENCED ANY CHANGES TO YOUR HEALTH IN THE PAST YEAR?						
	BONE AND JOINT QUESTIONS	**YES**	**NO**		**MEDICAL QUESTIONS**	**YES**	**NO**
20	Do you have a bone, muscle or joint injury that bothers you?			38	Are you trying to, or has anyone recommended that, you gain or lose weight?		
21	Do any of your joints become painful, swollen, feel warm or look red?			39	Are you on a special diet or do you avoid certain types of foods? If so, what: _____ _____		
22	Have you had any episodes of back pain or had a back injury?						
	MEDICAL QUESTIONS	**YES**	**NO**		**FEMALES ONLY**		
23	Do you cough, wheeze, or have difficulty breathing during or after exercise?			40	How many periods have you had in the last 12 months?		
24	Have you used an inhaler or taken asthma medicine?				**OCCUPATIONAL HEALTH**	**YES**	**NO**
25	Do you have groin pain, or a painful bulge or hernia in the groin area?			41	How many working fires did you respond to where you were involved in active fire suppression (including interior/exterior attack, ventilation, or search & rescue)?	*Estimate # if needed.* _____	
26	Do you have any rashes, pressure sores or other skin problems?						
27	Have you had a head injury or concussion?			42	Have you been exposed to smoke or products of combustion from active fires at any time when you were not wearing SCBA (including overhaul or after fire is extinguished)?		
28	Have you had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?						
29	Do you have a history of seizure disorder?						
30	Do you have headaches with exercise?			43	Have you responded to any HAZMAT incidents where you were, or may have been, exposed to chemicals or other toxic substances?		
31	Have you had numbness, tingling or weakness in your arms or legs after being hit or falling?						
32	Have you been unable to move your arms or legs after being hit or falling?			44	Have you responded to any medical calls where you were, or may have been, exposed to or come into contact with substances such as blood, saliva or other bodily fluids?		
33	Have you become ill while exercising in the heat?						
34	Do you get muscle cramps when exercising?				If yes, was this investigated by a physician?		
35	Do you have problems with your eyes or vision?						
36	Do you wear glasses or contact lenses?						
37	Do you worry about your weight?						

Please explain any "yes" answers here, referring to the question # in brackets

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_____

_____

_____

Is there anything else you would like to share about your health, changes in your health, or your family's health, in the last year?

_____

_____