4/25/19

Dear Department Chief,

A question came up recently regarding whether volunteer firefighters need to be tested for Color Blindness. There is extensive data supporting the notion that Color Blindness should not be an automatic exclusion as a firefighter. However, there is nothing we could find that supports eliminating as part of anyone's protocol.

Columbia Memorial Health (CMH) does not have an ophthalmologist or optometrist on staff and therefore can not determine the degree of Color Blindness that a firefighter may have. CMH will no longer test for color vision on firefighter physicals. Please see updated "Note" that will appear on the "Authorization For Firefighter Physical" form and the "Firefighter Evaluation" form:

"Note: Respiratory FIT Testing, Immunization requirements and Color Vision testing are not part of the firefighter exam and are at the discretion of the individual department policies and protocols."

As always, should you have any questions, please contact Karen Franceschi at 518-929-5664.

Sincerely,

Ronald J. Pope, DO

Vice President of Medical Services, Care Centers

Columbia Memorial Health

71 Prospect Avenue

Hudson, NY 12534

CMH
Columbia Memorial Health

71 Prospect Ave, Hudson, NY 12534 | 518-828-7601

AUTHORIZATION FOR FIREFIGHTER PHYSICAL

To be completed by Fire Company and given to firefighter to hand in at check in for physical.

Facility: (Please check)

☐ Hudson Medical Care (No appointment needed: Sundays 10 am-4 pm)
Hudson River Bank & Trust Foundation Medical Office Building, Hudson, Suite 130.

☐ Valatie Rapid Care (Call for appointment: 7 days a week 518-758-4300)
2827 Route 9, Valatie

☐ Copake Rapid Care (No appointment needed: 7 days/week from 9 am–7:30 pm)
283 Mountain View Rd, Copake

☐ Red Hook (Call for appointment: M-F 845-7585-9118)
7385 South Broadway, Red Hook

☐ Coxsackie Family Care
9 Law Street Coxsackie, NY 12051 (Call for appointment M-F 518-731-2120)

To Whom it May Concern:

Please perform a firefighter physical examination for _____,
who is a member or has applied for membership in the _____
Department and needs an annual physical exam.

Sincerely,

_____ _____ _____
Signature Title Date

****

To be completed by CMH: **Physical Exam Acknowledgement**

The above-named firefighter was given a firefighter physical exam on the following date: _____

Note: Respiratory FIT testing, Immunization requirements and Color Vision testing are not part of the firefighter exam and are at the discretion of the individual department policies and protocols.

Approved for: Category: A B C D or Failed (circle one)

Provider Name: _____ Signature: _____ Date:_____

DISABILITY HISTORY

Are you currently receiving any kind of subsidized disability payments, been declared permanently disabled, or have any physical/medical condition that would prevent you from holding a job and you are in the process of filing for disability?

☐ YES, I am receiving disability and/or considered disabled.

☐ NO, I am not receiving disability and/or considered disabled.

If marked YES, please give details to include the date that you were declared disabled and any description of the condition that is the source of the disability to the occupational health provider.

☐ I am willing and provided information about my disability to the occupational health provider.

☐ I am NOT willing and WILL NOT provide information about my disability to the occupational health provider.

☐ YES ☐ NO I am authorizing release of this form to my department chief / administrator.

Name: _____ Date: _____

Signature: _____

PROVIDER ATTESTATION

The above named firefighter/applicant has provided information about their disability with me during the course of the physical. Based upon the provided information and results of the physical examination, I find that the firefighter/applicant will be able to safely perform the duties required of the firefighter classification being identified on page 1.

Signature: _____ Date: _____

1 copy in patient chart
1 copy to fire district (If Yes checked above)

CANCER HISTORY

Have you ever been treated or currently being treated for the following types of cancer:

YES ☐ NO ☐ Lung

YES ☐ NO ☐ Prostate

YES ☐ NO ☐ Breast

YES ☐ NO ☐ Lymphatic

YES ☐ NO ☐ Hematological

YES ☐ NO ☐ Digestive

YES ☐ NO ☐ Urinary

YES ☐ NO ☐ Neurological

YES ☐ NO ☐ Reproductive Systems

YES ☐ NO ☐ Melanoma

If any are marked YES, please give details to include the date when a diagnosis of cancer was made and the current status of treatment:

_____

_____

_____

_____

_____

YES ☐ NO ☐ I authorize a copy to be given to my department chief or administrator

Name: _____ Date: _____

Signature: _____

1 copy in patient chart
1 copy to fire district (if Yes is checked)

COLUMBIA MEMORIAL HEALTH

FIREFIGHTER EVALUATION FORM

PLEASE COMPLETE THE FOLLOWING INFORMATION

Fire Company: _____

Name: _____ Testing Location: _____

Social Security #: _____/_____/_____ Date of Birth: _____

Home Address: _____

Home Phone: _____ Primary Care Physician: _____

PCP (Primary Care Physician) Phone: _____

PCP Address: _____

Category A: **Interior** Firefighting: Must be able to utilize a respirator, carry injured victims and perform strenuous activity with no physical restrictions.

Category B: **Exterior** Firefighting: Must be able to perform strenuous physical exertion and have no limitations and be able to use an air pack. It is very similar to category A.

Category C: **Exterior Support** Activities: This individual must be able to fight brush fires, do extrication, assist at structure fires, do mountain rescue, rope rescue, water rescue, as well as drive. They do not require use of an Air pack. They must be physically capable of performing these strenuous activities.

Category D: **Administrative/ Fire Police**: Must be able to stand for long periods without a chair directing traffic. Must be physically capable of jumping to safety should a vehicle be at risk of hitting them. Canes, crutches, severe arthritis are all automatically disqualified.

Which Category are you currently ? **A** **B** **C** **D** **None of these** **(circle one)**

Which Category are you requesting ? **A** **B** **C** **D** **None of these** **(circle one)**

__Fire Fighter Complete Exam				__Peak Flow (>350) done	Pass	Fail	
__EKG	Pass	Fail	N/A	__ Whisper Test (at 5 ft)	Pass	Fail	N/A
__Urine Dip	Pass	Fail	N/A	__ Fingerstick Glucose	Pass	Fail	N/A

Note: Respiratory FIT testing, Immunization requirements and Color Vision testing are not part of the firefighter exam and are at the discretion of the individual department policies and protocols.

Comments:

Approved For Category: A B C D None

Provider Name: _____ **Signature of provider:** _____ **Date:** _____

Revised: 4/19

Physical Questionnaire

Pulmonary

Have you ever had any of the following pulmonary or lung illnesses?

Yes___No ___ Asbestosis
Yes___No ___ Asthma
Yes___No ___ Broken Ribs
Yes___No ___ Chronic Bronchitis
Yes___No ___ Emphysema
Yes___No ___ Lung Cancer
Yes___No ___ Pneumonia Pneumothorax (collapsed lung)
Yes___No ___ Silicosis
Yes___No ___ Tuberculosis
Yes___No ___ Have you ever had any lung or chest surgeries or injuries?
If "Yes", please explain: _____
Yes___No ___ Have you ever had a chest X-Ray? Please give the approximate date of your most recent:
Date: _____ Was it NORMAL? ABNORMAL? NOT SURE? (please circle one)

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

Yes___No ___ Shortness of Breath
Yes___No ___ Shortness of breath when walking fast on level ground to walking up a slight hill or incline
Yes___No ___ Shortness of breath when walking with other people at an ordinary pace on level ground
Yes___No ___ Have to stop for breath when walking at your pace on level ground
Yes___No ___ Shortness of breath when washing or dressing yourself
Yes___No ___ Shortness of breath that interferes with your job
Yes___No ___ Coughing that produces phlegm (thick sputum)
Yes___No ___ Coughing that wakes you early in the morning
Yes___No ___ Coughing up blood in the last month
Yes___No ___ Wheezing
Yes___No ___ Wheezing that interferes with your job
Yes___No ___ Chest pain when you breathe deeply
Yes___No ___ Allergic reactions that interfere with your breathing
Yes___No ___ Do you have any other lung problems that you have been told about?
If "Yes" Please explain: _____
Yes___No ___ Has your doctor recommended that you currently limit any of your work, recreation or hobby activities due to any of the lung problems listed above?
If "Yes" please explain: _____

Cardiovascular

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

Yes ___ No ____ Angina
Yes ___ No ____Coronary artery bypass surgery or an angioplasty/balloon catheterization YEAR _____
Yes ___ No ____ Heart arrhythmia (irregular heart beat)
Yes ___ No ____Heart attack (MI)
Yes ___ No ____Heart Failure
Yes ___ No ____ Heart Murmur
Yes ___ No ____ High Blood Pressure
Yes ___ No ____ Swelling in your legs or feet (not caused by walking)

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

Yes ___ No ____ Frequent pain or tightness in your chest at rest
Yes ___ No ____ Pain or tightness in your chest during physical activity
Yes ___ No ____ In the past two years, have you noticed your heart skipping or missing a beat
Yes ___ No ____Heartburn or indigestion that is related to physical activity
Yes ___ No ____ Any other symptoms that you think may be related to heart or circulation problems:
Please explain: _____
Yes ___ No ____Have you ever had an EKG (electrocardiogram)? Please give the approximate date of your most recent EKG : _____
Was it NORMAL , ABNORMAL, DON'T KNOW (please circle one)
Yes ____ No ___Have you ever had a Stress Test or treadmill EKG (echocardiogram)? Please give the approximate date of your most recent stress test: _____
Was it NORMAL, ABNORMAL, DON'T KNOW (please circle one)

Neurologic

Yes ___ No ____Frequent headaches
Yes ___ No ____ Multiple Sclerosis
Yes ___ No ____ Paralysis/Spinal Cord injury
Yes ___ No ____ Seizures/Epilepsy (fits)
Yes ___ No ____ Stroke/ Cerebral Vascular Accident
Yes ___ No ____Any other neurological illness or injury? Please explain: _____
Yes ___ No ____ Has your doctor recommended that you **currently** limit any of your work, recreation or hobby activities due to any of the neurological problems?
If "YES" Please explain: _____

Gastrointestinal/Kidney

Have you ever had the following Intestinal/Stomach/Kidney conditions?

Yes ___ No ___ Appendicitis
Yes ___ No ___Gallbladder
Yes ___ No ___Hiatal Hernia
Yes ___ No ___Liver Disease (Cirrhosis, Hepatitis)
Yes ___ No ___ Reflux (GERD)
Yes ___ No ___Ulcers
Yes ___ No ___Any other intestinal or kidney illness or injury? Please explain:_____
Yes ___ No ___ Has your doctor recommended that you currently limit any of your work, recreation or hobby activities due to any of the intestinal or kidney problems listed?
If "YES" please explain: _____

EYES

Do you currently have any of the following vision problems?

Yes ___ No ___ Cataracts
Yes ___ No ___ Color Blind
Yes ___ No ___ Glaucoma
Yes ___ No ___ Lost vision in either eye (temporarily or permanently?)
Yes ___ No ___ Wear contact lenses or wear glasses
Yes ___ No ___ Any other eye or vision problem? Please explain: _____

EARS

Do you currently have any of the following hearing problems?

Yes ___ No ___ Broken ear drum
Yes ___ No ___ Difficulty hearing _____ Left ear AND/OR _____ Right ear
Yes ___ No ___ Ringing in the ears
Yes ___ No ___ Wear a hearing aid
Yes ___ No ___ Any other hearing or ear problems? Please explain: _____

Musculoskeletal

Do you currently have any of the following musculoskeletal problems?

Yes ___ No ___ Arthritis
Yes ___ No ___ Back pain, including sciatica, herniated or bulging disk, arthritis, or muscle strain
Yes ___ No ___ Difficulty climbing a flight of stairs or ladder carrying more than 25 pounds
Yes ___ No ___ Difficulty or weakness fully moving your arms and legs
Yes ___ No ___ Difficulty bending at your knees
Yes ___ No ___ Difficulty squatting to the ground
Yes ___ No ___ Gout
Yes ___ No ___ Pain or stiffness when you lean forward or backward at the waist
Yes ___ No ___ Any other muscle or skeletal problem that interferes with performing work activities Including using a respirator? : Please explain: _____
Yes ___ No ___ Has your doctor recommended that you currently limit any of your work, recreation or hobby activities due to any of the musculoskeletal problems listed? If "YES" please explain: _____

General Medical

Do you have any of the following?

Yes ___ No ____Anemia
Yes ___ No ____ Cancer
Yes ___ No ____Claustrophobia (fear of closed-in places)
Yes ___ No ____ Diabetes (sugar disease)
Yes ___ No ____ Thyroid disease
Yes ___ No ____ Trouble smelling odors

Tobacco and Alcohol

Yes ___ No ____ Do you currently smoke tobacco
Yes ___ No ____ Have you in the past smoked tobacco
If you have smoked or do smoke, how many years have you smoked? _____
How many packs per day have/do you smoke _____
Yes ___ No ____Do you drink alcohol
On the average, how much of the following do you drink per week?
Beer:_____cans/bottles Wine: _____ glasses Whiskey/liquor:_____jiggers/shots

Family Medical History

If a family member has had any of the following medical conditions, please write the number which corresponds to that family member in the space provided.

1. Father 2. Mother 3. Grandparents 4.Brother/Sister 5. Children

_____ Cancer _____ Liver Disease/Cirrhosis _____ Diabetes _____ Seizure/Epilepsy

_____ Hypertension _____ Heart Disease _____ Lung Disease

Yes ___ No ____ Is your father still living? If "NO", what age did he die? _____
What was the cause of his death?_____
Yes ___ No ____ Is your mother still living? If "NO", what age did she die? _____
What was her cause of death? _____

Respiratory Protection

Check the type of respirator you will use (you can check more than on category)

a. _____ N, R, or P disposable respirator (filter- mask, non-cartridge type only)

b. _____ Other type (for example: half- or full-face piece type, powered- air purifying, supplied air, self-contained breathing apparatus)

Yes ___ No ____ Have you worn a respirator? If "YES", please circle what type(s):

Disposable/paper mask
Filter/cartridge style or half or full face piece mask
Military gas mask
Self-Contained Breathing Apparatus (SCBA)
Supplied- Air or Type C respirator

If you have used a respirator, have you ever had any of the following problems related to using respirator?

Yes ___ No ____ Anxiety
Yes ___ No ____ Eye Irritation/Difficulty seeing in your mask
Yes ___ No ____Shortness of breath
Yes ___ No ____ Skin Allergies or rashes
Yes ___ No ____ Any other problem that interferes with your use of a respirator?
Please explain: _____

Protective Equipment

Yes ___ No ____ Do you have a latex or rubber sensitivity
Yes ___ No ____ Do you get rashes after wearing protective clothes
Yes ___ No ____ Do you become overheated wearing protective clothing

Health Status

Please indicate what you believe your health status is today: __Excellent_____Good_____ Fair ___ Poor

Yes ___ No ____ Have you been examined or treated by a health care provider within the last 12 months for?

Injury (please explain) _____
Illness (please explain) _____
Routine physical or follow-up (please explain)_____

Surgical History

Please list any surgical procedure you have had and if possible, list dates (or approximate) dates:

Surgical procedure	Date
Surgical procedure	Date
Surgical procedure	Date
Surgical procedure	Date
Surgical procedure	Date
Surgical procedure	Date
Surgical procedure	Date

Medication List

Please list any medications that you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

I have answered this health questionnaire completely and honestly and understand I can review any questions with my examiner if I am unsure or need to further explain.

Employee Signature: _____ **Date:** _____

Authorization for Release of Information

I, the undersigned, authorize the release of information to Columbia Memorial Hospital from:

Name/ Primary Care Provider : _____

Address : _____

City: _____ **State** _____ **Zip Code** _____

Telephone # (_____) _____-_____ **Fax #** (_____) _____- _____

I expressly authorize the release of the following information from my health file:

_____

_____

_____

Print: _____ **Print:** _____

Sign: _____ **Sign:** _____

Date: ____/___/_____ **Date:** ____/___/_____

To the Recipient: This information has been disclosed to you from confidential records, which are protected by the federal and state law. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure is in violation of state and federal law and may result in a fine or jail sentence, or both.

AUDIOMETRIC EVALUATION

Name: _____ SSN: _____

Employer:_____ Periodic [ ]

DOB: _____ Age: _____ Date: _____ Pre-employment [ ]

Occupation: _____ Re-test [ ]

Please Circle answer to questions 1-11:

1. Have you had any loud noise exposure in the past 14 years (prior to test)? YES NO
2. Are you experiencing a ringing, buzzing, or plugging sensation in either ear today? YES NO
3. Do you ever have ringing in your ears? YES NO
4. Do you have a "head cold" or congestion today? YES NO
5. Have you ever been exposed to loud noise from military activities? YES NO
   If "YES", please explain the type of noise:_____
   Length of time (years) of exposure: _____ years
6. Have you ever worked a noisy job? YES NO
   If "YES" please explain: _____
   Length of time (years) of exposure: _____ years
7. Have you had regular exposure to any of the following non-occupational noise sources? :
   Power or Air tools _____ Target shooting or hunting_____ Chain Saws____
   Motorcycles/snowmobiles_____ Loud Music _____ Other: _____
8. Have you ever been found to have a hearing loss? YES NO
   If "YES" please explain: _____
9. Does anyone in your family have a hearing loss? YES NO
10. Do you wear a hearing aid? YES NO
11. Have you ever had any of the following? :

Ear infections	YES	NO	Diabetes	YES	NO
Ear Injury	YES	NO	Head Injury	YES	NO
Ear Surgery	YES	NO	Mumps/Measles/Scarlet Fever	YES	NO
Stroke	YES	NO			

Employee Signature: _____ Date: _____

Name: _____ Date: _____

Employer: _____ DOB: _____

Date of Exam: _____

PFT:
Reading #1_____.
Reading # 2_____.
Reading # 3_____.
Average : _____.

Blood Pressure: _____/_____ Pulse: _____ regular/irregular

Height: _____ (in) Weight: _____ (lbs)

Fingerstick Glucose: Normal / Abnormal

Urine Dip: Normal / Abnormal (presence of glucose, protein and/blood?)

Vision **Corrective lenses?** Yes or No

Vision	**OD (Right)**	**OS (Left)**	**OU (both)**
Distance	20/	20/	20/
Near	20/	20/	20/
Peripheral			

Hearing **Perceives whisper at five (5) feet?** **AS** **Yes or No** **AD** **Yes or No**

Physical Exam	Normal	Abnormal	Comments
1. Eyes			Abnormal discs or fundi? Unequal pupils? Cataracts?
2. Ears			TM Scarring? TM Perforation? Excess cerumen?
3. Mouth/Throat			Dentures? Poor dentiltion Ulcers? Erythema?
4. Neck			Lymph nodes? Thyroid? Bruit?
5.Lungs			Wheezes? Rales? Diminished breath sounds?
6.Heart			Murmur? Irregular rhythm?
7.Abdomen			Masses? Tenderness? Organomegaly? Hernia? Prostate? Stool guaiac?
8.Musculoskeletal			Clubbing? Edema? Deformity? Spine? Varicosities? Gait? Weakness? Atrophy? Decreased ROM?
9.Neurologic			Reflexes? Motor? Sensory? Cranials?
10.Skin			Scars? Moles? Rashes? Erythema? Excoriation? Scaling? Tattoos?

I certify that I have reviewed the examination form and performed a physical examination on this patient.

Examiner's Signature: _____ Date: _____

Title of Examiner: _____

A referral has been made for further evaluation to: _____

Comments: _____