



Medical History Form

Fire Ops 101

NAME: _____

Please list any current symptoms within the last 14 days

	YES	NO
Cough	_____	_____
Trouble Breathing	_____	_____
Sore Throat/Hoarseness	_____	_____
Runny Nose/Drainage	_____	_____
Sinus Pain	_____	_____
Ear Aches	_____	_____
Fever	_____	_____
Chills	_____	_____
Muscle Aches	_____	_____
Eye Problems	_____	_____
Nausea/Vomiting	_____	_____
Diarrhea	_____	_____
Abdominal Cramps	_____	_____
Blood in Urine	_____	_____
Burning upon Urination	_____	_____
Blackouts/Fainting	_____	_____

Past Medical History

	YES	NO
Asthma	_____	_____
Emphysema/COPD	_____	_____
Thyroid Problems	=====	_____
Diabetes	=====	_____
High Blood Pressure	_____	_____
Heart Disease	=====	_____
Cancer	=====	_____
Pneumonia	=====	_____
Bronchitis	=====	_____
Blood Clots	=====	_____
Orthopedic (Bone) History	_____	
Other:	_____	
 Surgeries:	_____	

Explain:

Reviewed by: _____

OK to participate: YES _____ NO _____