NORTHAMPTON COUNTY
Department of EMERGENCY MEDICAL SERVICES

STANDARD OPERATING GUIDELINES

TOPIC: **Physical Exam & Health History**	SOG #: **2.3.1**

Status: ACTIVE	Written: 10/26/2004
Written by: Hollye B. Carpenter	Revised: 01/01/2013
Approved by: Hollye B. Carpenter	Adopted: 01/01/2013

Part I: EMS Provider Information:

Please complete Part I and II before visiting the doctor.
Please Print

Name: _____
Last *First* *Middle*

Physical Address:

Mailing Address:

Telephone #s: *(Home)* *(Work)* *(Cell)*

Date of Birth:

Emergency Contact: (Name) (Relationship)
(9-1-1 Address) (Phone #)

As an EMS provider of the Northampton County Department of Emergency Medical Services, he/she will be required to lift a minimum of 125lbs. This includes but is not limited to the lifting and moving of patients to and from stretchers, or any other device that aids in movement of patients; pulling, pushing and controlling the movement of machinery (i.e. oxygen cylinders, cardiac monitors, backboards, stair chairs, and stretchers); performing CPR, viewing digital displays, monitoring oscilloscope readouts, hearing audible alarms, auscultation blood pressures and hearing heart and lung sounds. Other skills include but are not limited to: peripheral vein-puncture, endotracheal intubation and administering pharmaceutical agents.

I request this report be sent to:

Health and Safety Officer
Northampton County Department of Emergency Medical Services
PO Box 235
Eastville, VA. 23347.

I hereby attest the medical information supplied includes all medical conditions which would affect my performance and job duties. I authorize release of current medical information on my medical history and/or current condition to the Health and Safety Officer. If false information is given or if significant information is withheld, I understand my employment or affiliation could be jeopardized.

Employee's signature: Date:

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Health History

Part II. EMS Provider: The next three pages deal with health history. Please complete this part before visiting the doctor. Please place a check on the appropriate line for each yes or no answer and provide details as necessary. Provide this to the doctor for review during your physical.

EMS Provider's Name:

	No	Yes	if yes, give details
I. Have you had any surgeries/operations?			
On your back, arm leg, or knee?	_____	_____	_____
To treat a hernia?	_____	_____	_____
Varicose veins?	_____	_____	_____
Other operations?	_____	_____	_____
II. Allergies - Have you ever had or do you currently have?			
Serious allergy?	_____	_____	_____
Chronic skin problems?	_____	_____	_____
Problems with "easy bruising"	_____	_____	_____
Chemical or jewelry rash/sensitive?	_____	_____	_____
III. Neuro- Have you ever had or do you currently have?			
A psychiatric or emotional problem?	_____	_____	_____
Numbness/weakness/paralysis?	_____	_____	_____
Dizziness or fainting spells?	_____	_____	_____
Severe/frequent or migraine headaches	_____	_____	_____
Head injury, concussion, or skull fx	_____	_____	_____
Do you take any medications for nerves or psych disorders	_____	_____	_____
IV. Eyes/Ears- Have you ever had or do you currently have?			
Hearing Loss?	_____	_____	_____
Frequent ear infections?	_____	_____	_____
Ringing in the ears?	_____	_____	_____
Other ear problems?	_____	_____	_____
Glaucoma or cataracts?	_____	_____	_____
Red eye?	_____	_____	_____
Eye injury?	_____	_____	_____
Other eye problems?	_____	_____	_____

Date of last Eye Exam and with whom? _____

Health History Continued

EMS Provider's Name:

	No	Yes	if yes, give details
V. Head/Neck- Have you ever had or do you currently have?			
Recent problems w/ teeth/dentures?			
Frequent mouth ulcers/infections?			
Frequent sore throats?			
Trouble with thyroid?			
Problem requiring radiation treatment?			
Date of last dental exam and with whom?			
VI. Lungs- Have you ever had or do you currently have?			
Asthma or wheezing?			
Coughed up any blood?			
Shortness of breathe without apparent reason?			
TB or positive skin test for TB?			
Pneumonia or pleurisy?			
Pain or tightness in the chest?			
More than three episodes of bronchitis in 1 year?			
Ever smoked tobacco in any form?			How long (years)? Packs per day?
			When did you quit?
Had a chest x-ray?			Where and when?
VII. Heart – Have you ever had or do you currently have?			
Rheumatic fever or heart murmur?			
Heart disease?			
Treated of a heart condition?			
Unusually cold or bluish hands or feet?			
High blood pressure?			
If yes, how is it treated?			Medicine Diet Exercise
History of elevated cholesterol?			
Anemia or any blood clots or poor circulation?			
Chest pain with activity?			

Health History Continued

EMS Provider's Name:

	No	Yes	if yes, give details
VIII. GI- Have you ever had or do you currently have?			
Ulcers?			
Hiatal hernia?			
Indigestion, pain, or unusual burning in the stomach?			
Vomiting of blood?			
Bloody/tarry bowel movements?			
Colitis or nervous stomach?			
Yellow jaundice or hepatitis?			
Gall bladder disease?			
IX. Kidneys - Have you ever had or do you currently have?			
Bladder or kidney infections?			
Kidney Stones?			
Burning, discomfort, frequency on urination?			
Hernia?			
Blood in urine?			
X. Miscellaneous- Have you ever had or do you currently have?			
Diabetes of sugar in urine?			
Cancer of any kind?			
Been tested for HIV?			
XI. Muscle - Skeletal - Have you ever had or do you currently have?			
Arthritis, rheumatism, neck, back or spine injury or disease?			
Been treated for a back problem?			
Recurrent stiffness or back pain?			
Hand or wrist injury or problem?			
Hip or knee injury or problem?			
Ankle or foot injury or problem?			
Problem with heavy lifting?			
Problem with standing or sitting for long periods of time?			
Any broken bones?			

Health History Continued

EMS Provider's Name:

	No	**Yes**	**if yes, give details**
XII. For Females Only—Have you ever had or do you currently have?			
Menstrual irregularities?	_____	_____	_____
Recurrent problems involving the female organs?	_____	_____	_____
Breast masses or lumps?	_____	_____	_____
Do you practice monthly breast self-exams?	_____	_____	_____
Date of last pap smear and with whom:	_____		
XIII. For Males Only—Have you ever had or do you currently have?			
Prostate or testicular problems	_____	_____	_____
Breast tenderness, swelling, or lumps?	_____	_____	_____
Do you practice monthly testicular self-exam?	_____	_____	_____

I certify all the above information is true and complete to the best of my knowledge.

Employee's Signature:

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Part III: INSTRUCTIONS: This part must be completed by a physician (preferably by our designated department physician) and an official stamp affixed at the bottom of the last page. Copies of lab reports, titers, etc. must also be attached. All sections of this form must be complete.

EMS Provider's Name:
Height: Weight:
Vital Signs: Temp: Pulse: Resp: B/P:
Vision: OD: OS: corrected? No Yes explain:
General Appearance:
Ears:
Nose:
Throat:
Neck:
Breasts:
Chest:
Cardiovascular System
Abdomen:
GI system:
GU system:
CNS/reflexes:
Back:
Extremities:
Is there evidence of misuse of illicit drugs or alcohol? No Yes If yes please explain:
Describe any conditions currently being treated?
21. Allergies:

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Part IV TESTS: Please attach all results of the following tests and provide any comments related to each:

EMS Provider Name:
EKG – 12 Lead:
Urinalysis:
Peak flow test:
Hearing test:
Color Vision test:
Lab tests: Multilevel profile, including lipids, sugar, liver, & kidney functions (CBC, any other lab tests that are appropriate to the patient and/or their condition):
Physician summary of above testing and recommended follow-up, if any.

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Part V Summary: This section is to ensure patient safety and welfare. These technical standards are an important part of the EMS provider's everyday duty activities.

EMS Provider's Name:

PHYSICIAN: Please answer the following questions:

YES / NO	Sufficient eyesight to observe patients; manipulate equipment and accessories, visually monitor patients in dimmed light via video monitors, and evaluate radiographs for quality.
YES /NO	Sufficient hearing to communicate with patients and other members of the health care team, monitor patients via audio monitors and hear background sounds during equipment operations.
YES /NO	satisfactory speaking, reading, and writing skills to effectively and promptly communicate in English.
YES /NO	Sufficient gross and fine motor coordination to manipulate equipment and accessories. Lift a minimum of 125lbs., and to stoop, bend or promptly assist patients who become unstable.
YES / NO	Satisfactory physical strength and endurance to move immobile patients to or from a stretcher or wheelchair, work with arms extended overhead, stand in place for long periods of time, and carry 125lbs., while walking.
YES /NO	Satisfactory intellectual and emotional functions to ensure patient safety and exercise independent judgment and discretion in the performance of assigned responsibilities.

YES/NO Is there anything in the EMS provider's past medical history that would preclude his/her ability to work as an employee of Northampton County Department of Emergency Medical Services?

Comments:

YES/NO Would you recommend duty (for a new EMS provider) or continuance (for a previous EMS provider)?

Comments:

I have this date given _____ a careful physical examination and find him/her in _____ health.

Physician's Signature **Date:**

Name of Physician (please print):

Address of Physician:

Phone Number of Physician: