SHILOH FIRE

HEALTH INFORMATION FORM

Name: ______________________ **Sex:** M_____ F_____

SSN: ______________________ **DOB:** ___________

Height: __________________ **Weight:** _________________ **Age:** _____________________________

The information obtained from this document is intended for medical use only in the event you become ill during the course of trainng or during your course of duty. The information contained is privileged medical information and for the expressed use of Medical Staff of the Health Care Institution you might be referred to for any care.

Medical History/Illness: Do you have or have you ever had? (Please check yes or no)

Cardiovascular (Heart)	**Yes**	**No**
Angina		
Congestive Heart Failure		
Heart Attack		
Heat Rhythm Problems		
Pacemaker		
Palpitations		
Other: Specify		

Neurological	**Yes**	**No**
Concussion		
Dizziness/Faiting Spells		
Migraine Headache		
Seizures		
Stoke		
Other: Specify		

Muscoloskeltal	**Yes**	**No**
Arthritis		
Back Injury		
Broken Bones		
Burssitis		
Other: Specify		

Eyes/Ears/Nose/Throat	**Yes**	**No**
Blindness		
Color Blindness		
Sinsitis		
Other: Specify		

Gastrointetinal	**Yes**	**No**
Bleeding Ulcers		
Peptic Ulcers		
Bleeding from Rectum		
Hepatitis		
Gallstones		
Other: Specify		

Pulmonary (Lungs)	**Yes**	**No**
Asthma		
Chronic Bronchitis		
Collapsed Lung(s)		
COPD		
Pneumonia		
Other: Specify		

Surgeries	**Yes**	**No**
Angioplasty		
Appendectomy		
Back Surgery		
Cholycystectomy		
Coronary Bypass		
Hip		
Open Fractures:		
Other: Specify		

Endocrine	**Yes**	**No**
Diabetes		
Other: Specify		

Blood	**Yes**	**No**
Anemia		
Clotting Disorder		
Other: Specify		

Medications (List)

Name	**Dosage**	**Allergies**

Patient Signature: ________________________________ **Date:** ____________________

Witness Signature: ________________________________ **Date:** ____________________