RIO HONDO COMMUNITY COLLEGE DISTRICT
DEPARTMENT OF PUBLIC SAFETY – FIRE TECHNOLOGY
11400 Greenstone Avenue • Santa Fe Springs • California • 90670-4620
(562) 941-4082 • FAX (562) 941-7382

Emergency Medical Technician
Health Questionnaire

MEDICAL HISTORY

(To be filled in by student. Please use ink and **PRINT CLEARLY**.)

TODAYS DATE: _____

NAME: _____ TELEPHONE: _____
Last First M.I.

PERMANENT ADDRESS: _____
Number / Street City / State Zip Code

DATE OF BIRTH: ____ - ____ - ____ PLACE OF BIRTH: _____ SOCIAL SECURITY NO: _____

DRIVERS LIC. #: _____ CLASS: _____ EXPIRATION DATE: _____ ☐ FEMALE ☐ MALE

EMERGENCY CONTACT: _____ RELATION: _____ PHONE: _____

FAMILY PHYSICIAN: _____
Name Address Telephone

HEALTH HISTORY

Check conditions you have had or now have. Show dates on non-chronic conditions.

- ❒ Allergies (severe)
- ❒ Anemia
- ❒ Arthritis
- ❒ Asthma
- ❒ Back Pain
- ❒ Back Problems
- ❒ Blackouts
- ❒ Bladder Conditions
- ❒ Bronchitis
- ❒ Cancer
- ❒ Chicken Pox
- ❒ Convulsive Disorder
- ❒ Crohn's Disease
- ❒ Diabetes
- ❒ Dizziness
- ❒ Draining Ear
- ❒ Ear Infections
- ❒ Epilepsy
- ❒ Fainting
- ❒ Gall Bladder Disease
- ❒ Headaches (Frequent)
- ❒ Headaches (Migraine)
- ❒ Heart Trouble
- ❒ Hepatitis
- ❒ Hernia
- ❒ High Blood Pressure
- ❒ Impairment of Hearing
- ❒ Kidney Trouble
- ❒ Marked Fatigue
- ❒ Mononucleosis
- ❒ Nervous Breakdown
- ❒ Other Blood Diseases
- ❒ Palpitation
- ❒ Persistent Cough
- ❒ Pneumonia
- ❒ Poliomyelitis
- ❒ Rheumatic Fever
- ❒ Rubella
- ❒ Rubeola
- ❒ Seizures
- ❒ Skin Condition
- ❒ Smoking Habits
  Packs Daily:
  ❒ 1 ❒ 2 ❒ 3
- ❒ Stomach Conditions
- ❒ Thyroid Disease
- ❒ Treatment for Alcohol
- ❒ Treatment for Drug Addiction
- ❒ Tuberculosis
- ❒ Ulcers

List any other illness you have had. (include dates) _____

List medications. Prescribed: _____

Over the counter taken regularly: _____

Surgical Procedures. (Give date and nature) _____

Severe Accidents, including fractures. (Give date and nature) _____

Female Menstrual Disorders _____

Have you ever been treated for a nervous, mental or emotional problem? ❒ Yes ❒ No

If yes, give approximate dates: _____

and nature of problem: _____

IMMUNIZATIONS

Indicate which vaccinations and immunizations you have had. (Give dates) (WRITTEN proof of immunization is required)
NOTE: A Tetanus Diphtheria booster is required if none has been received within the last 10 years.

NURSE: Patient counseled regarding importance of not becoming pregnant within 3 months of vaccination? ❒ YES ❒ NO

Send to see primary medical physician if pregnant. ❒ YES ❒ NO

Nurse Name: _____ Signature: _____ Date: _____

MMR 1 _____ MMR 2 _____ Tetanus Diphtheria Booster _____ (within past 10 years)

Hepatitis 1 _____ Hepatitis 2 _____ Hepatitis 3 _____

* Women should not receive the Rubella vaccine if they are pregnant or might become pregnant within 3 months. However, if you are vaccinated and then find out you were pregnant at the time, it should not be a cause for concern. Rubella vaccine has never been known to harm an unborn child.
REP: Center for Disease Control

I understand that I will be subject to being dropped from the program if any statement on this form is found to be untrue.

Information on this form may be released to the clinical facilities in accordance with the policies of each facility as stated in the contracts between the facility and Rio Hondo College, Department of Public Safety - Fire Technology / EMT.

In the event of illness or injury occurring during my assignment at clinical facilities (hospitals and community agencies) the policies regarding emergency care for each facility will be followed.

Signature: _____ Date: _____

LAST NAME: _____ FIRST NAME: _____

PHYSICAL EXAMINATION (To be completed by Physician)

General Appearance

Height Weight BP Temperature Pulse Respiration

Skin Ears

Eyes Throat

Teeth Neck

Chest / Lungs

Heart: Before Exercise After Exercise

Abdomen Rectal Exam

Genitalia Hernia

Pelvic and Breast Exam (on females)

Pregnancy Test ☐ + ☐ - Female cadets must have a Urine Pregnancy Test.

Back Dorsal Spine

Extremities

Neurological Knee Jerk Reflex: rt ☐ normal ☐ abnormal
lt _____ ☐ normal ☐ abnormal

Additional information: _____

Recommendations: _____

HEARING						
	250	500	1000	2000	4000	6000
Right						
Left						
Audiometrist:						
Date:						

VISION SCREENING		
	Right	Left
Uncorrected		
Corrected		
Color Vision		
Wears ☐ Glasses ☐ Contact Lenses		
Examiner:		
Date:		

LABORATORY TESTS: The following laboratory tests are required, results of which must be attached to this form:

10 PANEL DRUG TEST

☐ Provided
☐ Sent to Other Facility for Testing

☐ Urinalysis Results: ☐ Pass ☐ Fail

☐ TUBERCULIN SKIN TEST (within 6 months of admission)

Date: _____ Reaction: _____

If TB skin test is positive, a chest X-ray is required.

☐ Chest X-ray (within one year of admissions)

Date: _____ Reaction: _____

This client has been examined and found physically acceptable for an Emergency Medical Technician Training Program. ☐ YES ☐ NO

Examining Physician: _____ **Date:** _____

Doctor's Signature: _____ **Doctor's License No:** _____

Address: _____ **Phone:** _____