Code 3 Medical Services LLC

Austin, TX

Phone: (512) 750-7758 Email: Lee@code3medicalservices.com

MEDICAL HISTORY AND PHYSICAL EXAMINATION

NAME _____ DATE _____
PLEASE PRINT LAST , FIRST MIDDLE (AS ON DRIVERS LICENSE)

ADDRESS _____
NUMBER STREET (INCLUDE. APT. NO.) CITY STATE ZIP

BIRTH DATE _____ AGE _____ SEX _____
MONTH DAY YEAR

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING?

Yes	No		Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	Nervous stomach	☐	☐	Head or spinal injuries
☐	☐	Kidney disease	☐	☐	Rheumatic Fever	☐	☐	Seizures, fits or convulsions
☐	☐	Tuberculosis	☐	☐	Muscular disease	☐	☐	Any other nervous disorder
☐	☐	Syphilis, Gonorrhea, Herpes	☐	☐	Psychiatric disorder	☐	☐	Any permanent health defect
☐	☐	Allergies	☐	☐	Heart disease	☐	☐	Suffering from any other disease
☐	☐	Diabetes	☐	☐	Gastrointestinal ulcer	☐	☐	High blood pressure
☐	☐	Thyroid disease	☐	☐	Cancer	☐	☐	Swelling of legs or ankles
☐	☐	Chest pain	☐	☐	Varicose veins	☐	☐	Chronic cough or lung disease
☐	☐	Vascular disease	☐	☐	Hepatitis	☐	☐	Arthritis
☐	☐	Alcohol or drug abuse	☐	☐	Birth defects	☐	☐	Trick knee, elbow, joint or back
☐	☐	Have you ever been refused or lost a job for health reasons	☐	☐	Hernia	☐	☐	Do you take any medicine regularly
			☐	☐	Fainting or dizziness	☐	☐	Long confinement by illness or disease

EXPLAIN ANY "YES" ANSWERS: _____
_____
_____
_____

DOCTORS OFFICE USE ONLY BELOW THIS LINE

PHYSICAL EXAM: Temp. _____ Resp. _____ BP _____/_____ Pulse < exercise _____ Pulse > exercise _____

General appearance & development: Good _____ Fair _____ Poor _____ Height _____ Weight _____

	WNL	Abnormal (describe)		WNL	Abnormal (describe)
Skin & hair			Chest, breath sounds		
Head			appearance		
Eyes			Heart		
external			Abdomen		
fundoscopic			Genitalia		
Ears			Axial skeleton		
external			Upper extremities		
canal			Lower extremities		
tympanic membranes			Spine & Lower back		
Nose			Lymph nodes		
Mouth			Neurological		
tongue			reflexes		
teeth & gums			coordination		
Throat			balance		
Neck			motor		

Recommendation: Above individual is medically ☐ qualified ☐ unqualified or ☐ deferred - needs further evaluation, for employment as a firefighter and EMS first responder.

Physicians Address _____

Physicians Name (Print) _____ **Signature** _____