ARAPAHOE COMMUNITY COLLEGE

Health and History Questionnaire

One way to help eliminate the risk of persons being placed into situations that would pose undue risk of illness or injury to themselves, or to other personnel is to complete a health and work history form. Program staff will review this form. Please answer the following questions completely & frankly.

All medical information will be kept in strict confidence in your file.

Name: _____ Address: _____
Telephone #: _____ _____
Birth date: _____ Sex: Male ☐ Female ☐

Please answer all questions to the best of your knowledge. Any omissions, exclusions or falsifications on this questionnaire can result in eliminating you for consideration of acceptance in the Paramedic Program.

Your present health is: ☐ Good ☐ Fair ☐ Poor

Health History

Check Yes or No for the following if you have or have ever had:	Y	N		Y	N
Hospitalized in past 5 years	☐	☐	Back problems	☐	☐
Currently pregnant	☐	☐	GI disease/ulcers	☐	☐
Psychiatric disorder/treatment	☐	☐	Liver disease/gall bladder	☐	☐
Received a transfusion	☐	☐	Hernia	☐	☐
Chest x-ray – date of last one	☐	☐	Hemorrhoids	☐	☐
Headaches	☐	☐	Kidney disease	☐	☐
Epilepsy/seizures	☐	☐	Knee problems	☐	☐
Neck problems	☐	☐	Foot problems	☐	☐
Shoulder problems	☐	☐	Skin problems or dermatitis	☐	☐
Tendinitis/carpal tunnel/upper extremity problem	☐	☐	Arthritis	☐	☐
Heart problems	☐	☐	Cancer	☐	☐
High blood pressure	☐	☐	Diabetes	☐	☐
High cholesterol	☐	☐	Surgery	☐	☐
Lung problems/asthma	☐	☐	Rheumatic fever	☐	☐
High/Low Thyroid	☐	☐		☐	☐

If yes to any of the above, please explain:

_____
_____
_____

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Infections disease/vaccinations (Check Yes or No for the following)

Have you ever had:	Y	N	**Have you ever received**:	Y	N
Rubella (German Measles)*	☐	☐	Rubella (German Measles) vaccine	☐	☐
Rubeola (Measles)*	☐	☐	Measles (Rubeola) vaccine	☐	☐
Chicken pox (Varicella)*	☐	☐	Chicken pox (Varicella) vaccine	☐	☐
Hepatitis B	☐	☐	Mumps vaccine	☐	☐
Hepatitis – other than Hepatitis B	☐	☐	Hepatitis B vaccine - List Dates:	☐ ☐	☐ ☐
Tuberculosis (TB)	☐	☐			
Mumps*	☐	☐	Tetanus shot - List Date:	☐	☐
Strep infection	☐	☐	Meningitis	☐	☐

If yes to any of the above, please explain:

_____
_____
_____

* Proof of vaccine must be documented if not had the diseases.

Allergy History

Check Yes of No for the following:	Y	N		Y	N
Dust	☐	☐	Smoke	☐	☐
Fumes	☐	☐	Tetanus toxoid	☐	☐
Seasonal pollen/grasses/molds	☐	☐	Latex sensitive	☐	☐
Medications/sensitive	☐	☐	Chemicals/sensitive	☐	☐

If yes to any of the above, please explain:

_____
_____
_____
_____

List any medications you have taken in the past 3 months:

_____
_____
_____

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Occupational Work History

1. Do you currently have any physical, emotional, or medical limitations that would interfere with your ability to perform the activities required in the Program? ☐ Yes ☐ No
   If yes, please explain: _____

2. To the best of your knowledge, would participation in the Program aggravate any previous or known physical, mental, or medical impairments? ☐ Yes ☐ No
   If yes, please explain: _____

3. Have you ever been unable to work for an extended period of time (more than 2 weeks) due to any physical, medical, or mental condition? ☐ Yes ☐ No
   If yes, please explain: _____

4. Have you ever had an on-the-job accident or occupational illness? ☐ Yes ☐ No
   What kind of injury or illness did you sustain? Please list dates, time missed from work and injury:

   _____

   _____

   Were you hospitalized? ? ☐ Yes ☐ No Please list dates: _____

   Did you receive permanent work restrictions? ☐ Yes ☐ No

Check Yes or No for the following:	Y	N		Y	N
Exposed to asbestos?	☐	☐	Any permanent disability or impairment?	☐	☐
Exposed to excessive noise? (machines, shooting)	☐	☐	Exposed to chemicals at work?	☐	☐
Worn film badge?	☐	☐	Ever worn hearing protection?	☐	☐
Had an overexposure to ethylene oxide?	☐	☐	Worked with ethylene oxide?	☐	☐
Exposed to heavy metals, carcinogens, and lasers?	☐	☐	Worked with formaldehyde?	☐	☐

If yes to any of the above, please explain:

_____

_____

I certify that the answers and information given by me to the questions and statement contained in this questionnaire are true and correct to the best of my knowledge without omissions of any kind whatsoever, and understand that falsification, omissions, or misstatements are grounds for disqualification. I agree that _the Program shall not be liable in any respect if I am disqualified because of falsity of statement answers or omissions made by me in this questionnaire.

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Health History Form

(To be completed by Licensed Physician or Mid-level Practitioner)

Patient's Name: _____ Age: _____

Blood pressure: _____ Pulse: _____ Height: _____ Weight: _____

Vision: ☐ Corrected ☐ Uncorrected Far: O.D. 20/ Near: O.D. 20/
O.S. 20/ O.S. 20/
O.U. 20/ O.U. 20/

Color (Ishihara): _____

Rubella titer: _____
(or documentation of immunization)

Lab: Rubella titer (IGG) _____

Or,
- if DOB > January 1, 1957, documentation of two immunizations
- if DOB < January 1, 1957, documentation of one immunization

Varicella titer (if hx negative) _____

Hepatitis B titer (if hx negative) _____
(or documentation of Hep B series)

PPD or CXR _____

Other _____

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Physical Exam

General Appearance	Normal	Abnormal (Describe Below)	General Appearance	Normal	Abnormal (Describe Below)
Head / Neuro			Eyes		
Ophthalmoscopic exam			Ears		

Nose			Mouth & teeth		
Throat			Neck		
Skin			Chest & breast		
Lungs			Heart		
Pulses			Abdomen exam / Hernia		
Liver/spleen			Upper extremities		
Lower extremities			Spine		

Comments/Recommendations: _____

Restrictions: _____

Signature (MD/DO completing physical) & Credentials Name (please print) Date