



OKLAHOMA FIREFIGHTER PENSION & RETIREMENT SYSTEM

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INSTRUCTION TO THE PHYSICIAN

The following History and Physical with Lab Data are required by each applicant:

1. Complete medical and surgical history with dates.
2. Complete physical exam
3. Visual Testing: With and without correction
Binocular Vision
Color Vision
4. Audiometric testing with decibel level
5. Blood Work:
 - A. Comprehensive Metabolic Profile
 - B. Cholesterol
 - C. GGTP
 - D. Complete Blood Count
 - E. RPR
 - F. Hepatitis B Surface Antigen - HBSAG
 - G. Hepatitis B Core Antibody - HBCAB
 - H. Hepatitis C Antibody - HCV
 - I. Human Immunodeficiency Virus - HIV
6. Urinalysis with microscopic
7. X-ray-Chest (PA), lumbar spine (obtain only if history of back problems or surgery)
8. T.B. Skin Test
9. Pulmonary Function Test
10. Exercise Tolerance Test (Bruce Protocol) with interpretation
11. Complete knee examination form if history of knee surgery or significant injury
12. Urine Drug test must meet NIDA Standards.

SSN _____ Name _____ Date _____

Sex ____ Race _____ Age ____ Date of Birth _____

Address _____ Phone { } _____

City, State.Zip _____ Physician _____

- | | Yes | No |
|---|-------|-------|
| A. Have you ever: | | |
| 1. Received compensation for injury? | _____ | _____ |
| 2. Received a disability pension? | _____ | _____ |
| 3. Received medical discharge from armed forces? | _____ | _____ |
| 4. Been rejected for military service for medical reasons? | _____ | _____ |
| 5. Been hospitalized? | _____ | _____ |
| 6. Been operated on? | _____ | _____ |
| 7. Been rejected in any medical examination? | _____ | _____ |
| 8. Had allergic reactions to drugs, medications, blood transfusions, insect bites? | _____ | _____ |
| B. Have you ever had disease or injury to: (Circle affirmative items) | | |
| 1. Head, ears, eyes, nose, throat? | | |
| 2. Neck, back, hips, arms, legs, hands, feet? | | |
| 3. Joints: shoulder, elbows, knees, wrist, ankles? | | |
| 4. Heart: chest pain, palpitations, fainting, shortness of breath with exertion, sudden shortness of breath at night, feet swell, high blood pressure? History of Rheumatic fever or heart munnur; varicosities, deep leg pain (thrombophelbitis), heart attack, or stroke? | | |

5. Lungs: Unusual shortness of breath, sputum production, coughed up blood, chest pain, wheezing, recurrent infections, history of asthma, history of smoking cigarette __, pipe __, cigar __, other? How many per day? __. For how many years? __.
6. Breast: Pain, masses, nipple discharge? History of trauma, self breast exam and/or history of mammograms?
7. GI: Weight change, nausea or vomiting, vomiting blood, heart burn, abdominal pain, diarrhea or constipation of chronic or unusual character? History of ulcers, rectal bleeding, jaundice, laxative use/abuse?
8. GU: Pain when you urinate, blood colored urine, frequency or urgency to urinate? history of kidney stones, recurrent urinary tract infections, venereal diseases (syphilis, gonorrhea)?
9. Genital Tract:

Female: Age of Menses __; # of days between periods __; Date of last regular period __; History of severe pain during menstruation? Any history of unusual bleeding between periods? History of vaginal discharge? # of pregnancies __; # of abortions or miscarriages; __; # of deliveries __; Types of contraceptive currently used __; date and result of last pap smear? __.

Male: Penile pain, discharge or skin lesions? Testicular pain or masses. History of prostrate problems, hemias? History of vasectomy?
10. History of anemia, swollen and/or sore lymphnodes, easy or spontaneous bruising, excessive bleeding? History of any type of cancer?
11. History of retarded growth or development? Temperature intolerance, goiter, increased thirst, appetite, or frequency to urinate? History of diabetes, gout, recurrent skin rashes, unusual loss of hair?
12. History of tremor, paralysis, imbalance, muscle weakness or low sensitivity with the sense of touch? History of seizure disorder?
13. History of nervousness, anxiety, irritability? History of depression or suicide? History of psychiatric evaluation and/or treatment? History of drug or alcohol abuse?

C. Family medical history and any descriptive comments on positively answered question should be completed below.

D. All affirmative answered responses to the health screen if significant or pertinent to current health status of the applicant should be identified and outlined as to the time of onset, duration, location, aggravating or alleviating symptom, any associated symptoms that are characteristics of the problem.

I certify that the above health information is complete and true to the best of my knowledge. I authorize the medical examiner for the participating municipality to investigate any and all statements of health made herein.

Signature of Examinee

Date

Comments: _____

Physical Exam and Laboratory Assessment Form

Name: _____ City: _____ Date: _____

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Normal	Comments
1) Integument	_____
2) Heent	_____
3) Breast	_____
4) Chest	_____
5) Heart	_____
6) Abdomen	_____
7) Genitalia	_____
8) Rectal	_____
Stool Guaiac Results	_____
9) Musculoskeletal	_____
10) Neurologic	_____

Laboratory Results

1) Visual Acuity	Uncorrected R __ / L __ / Corrected R __ / L __ /	Binocular Vision _____ Color Vision _____
2) Audiometric: (500) __ / __ (1000) __ / __ (2000) __ / __ (3000) __ / __ (4000) __ / __ (6000) __ / __		

3) X-ray	A) PA Chest: _____	_____
	B) Lumbar Spine Series: _____	_____
	(Obtain only if history of back problem)	

4) Please submit copy of:

- | | |
|--|---------------------------------------|
| A. Comprehensive Metabolic Profile | G. Hepatitis B Core Antibody - HBCAB |
| B. Cholesterol | H. Hepatitis C Antibody - HCV |
| C. GGTP | I. Human Immunodeficiency Virus - HIV |
| D. Complete Blood Count | J. Urinalysis |
| ERPR | K. Drug Screen |
| F. Hepatitis B Surface Antigen - HBSAG | |

5) PPD Positive () Negative ()

Examiner's Signature _____

INFORMED CONSENT FOR TREADMILL EXERCISE TEST OF PATIENTS

In order to evaluate the functional capacity of my heart, lungs, and blood vessels, I hereby consent, voluntarily, to perform an exercise test. I understand that I will be questioned and examined by a doctor, and have an electrocardiogram recorded to exclude any apparent contraindications to testing. Exercise will be performed by walking on a treadmill, with the speed and grade increasing every three minutes, until limits of fatigue, breathlessness, chest pain, and/or other symptoms occur to indicate that I have reached my limit. Blood pressure and electrocardiogram will be monitored during the test. The test may be stopped sooner than my own limit if the technician's observations suggest that it may be unnecessary or unwise to continue.

The risks in performing this test are the risks of physical exercise and include irregular, slow and very rapid heart beats, large change in blood pressure, fainting, and very rare instances of heart attack. Every effort will be made to minimize these by the preliminary examination and by observation during testing. Emergency equipment and trained personnel are available to deal with unusual situations as they arise.

The information obtained will be treated as confidential and will not be released to anyone without my expressed written consent. The information may, however, be used for statistical or scientific purpose with my right of privacy retained.

I have read the above, understand it, and all questions have been satisfactorily answered.

Patient's Signature _____

Witness: _____

Date: _____

EXERCISE TOLERANCE TESTING WORKSHEET

Name: _____ Date: _____

Age: _____ Sex: __ Height: _____ Weight: _____

MPHR 100% _____ 85% _____ Medications: _____

HR	BP	ST DEPRESSION	011-ER EKG CHANGES	SYMPTOMS	
Sit _____					
Standing _____					
Hypervent. _____					
Minutes _____					
1 _____					STAGE 1
2 _____					1.7MPH
3 _____					10¾GRADE
4 _____					STAGE2
5 _____					2.5 MPH
E 6 _____					12%GRADE
X 7 _____					STAGE 3
E 8 _____					J.4 MPH
R 9 _____					14%GRADE
C 10 _____					STAGE4
I 11 _____					4.2MPH
\$ 12 _____					16%GRADE
E 13 _____					STAGE 5
14 _____					5.0 MPH
15 _____					18%GRADE
16 _____					STAGE6
17 _____					5.5 MPH
18 _____					20%GRADE
IMMED. _____					
R 1 _____					
E 2 _____					
C 3 _____					
O 4 _____					
V 5 _____					
E 6 _____					
R 7 _____					
y 8 _____					

TOTAL: _____ LAST STAGE: _____ TIME IN LAST STAGE: _____
 POST-EXERCISE P.E.: _____ MHR: _____ %OFMHR: _____
 MAX. SYSTOLIC B.P. _____ ST: _____ DOUBLE PRODUCT _____
 VQi R-WAVES: PRE: _____ POST: _____ RST: _____
 FUNCTIONAL AEROBIC IMPAIRMENT: _____
 INTERPRETATION: _____

SPIROMETRY REPORT

PHYSICIAN _____

TEST# ____ _

Name: _____

Date: _____

Age: _____ Height: _____ (cm) Weight: _____ (lbs.) Race ____ Sex ____

Diagnosis: _____

____ ASTHMA

____ BRONCHITIS

____ EMPHYSEMA

____ LUNG CANCER

____ TUBERCULOSIS

____ HYPERTENSION

____ CHESTPAJN

____ OTHER

HISTORY:

____ MOANING COUGH

____ SPUTUM COLOR

____ SPUTUM AMOUNT

SMOKING:

A. Never smoked

B. Used to smoke, stopped ____ years ago

C. Used to smoke ____ pack/day for ____ years

D. Continue to smoke

E. Have smoked ____ pack/day for ____ years

F. Smoke only a pipe or cigar

MEDICATIONS NOW TAKING:

TEST	PREDICTED	ACTUAL	%
Forced Vital Capacity (FVC) (L)			
Forced Expiratory Volume (FEV ₁) (L)			
Ratio FVC/FEV ₁			

INTERPRETATION:

NAME _____

KNEE EXAMINATION

RANGE OF MOTION:

Flexion: _____

Extension: _____

Crepitus with range of motion testing: Yes: _____

No: _____

DEFORMITIES:

Swelling/Effusion: _____

With leg in full extension, circumference of thigh 7 cm and 20 cm proximal to superior pole of patella:

L:	_____	+	_____
R:	_____		_____

TESTS:

McMurray's (medial meniscus): _____

Internal Rotation (lateral meniscus) with the foot internally rotated, movement from full flexion to extension): _____

Medial collateral ligament: _____

Lateral collateral ligament: _____

Anterior drawer (anterior cruciate ligament): _____

Patellar apprehension: _____

VMO on injured side compared to other: _____

Hop on each leg: _____

Squat: _____

Knee pain on rotation of hips and shoulders with feet together:

Yes: _____ No: _____

Knee pain on rotation of hips and shoulders with feet crossed:

Yes: _____ No: _____

X-rays, 3 views-AP, lateral and sunrise: _____