

**LSU FETI
HEALTH HISTORY QUESTIONNAIRE**

Health History	Please check "yes" or "no". If "yes" give details in REMARKS section.				
	Yes	No		Yes	No
Have you had any surgeries/operations:			Eyes/Ears-Have you ever had or do you currently have:		
On your back, arm, leg, or knee?			Hearing Loss?		
To treat a hernia?			Frequent ear infections?		
Varicose veins?			Ringing in ears?		
Other operations?			Other ear problems?		
Have you ever been hospitalized?			Glaucoma or cataracts?		
Allergy – Have you ever had or do you currently have:			Red eyes?		
Serious allergy?			Eye Injury/vision loss?		
Bad reaction to any medications?			Other eye problems?		
Advised not to take any medications?			Glasses/contacts?		
Skin – Have you ever had or do you currently have:			Date of last visual screen?		
Hives/eczema or rash?			Head/Neck –Have you ever had or do you currently have:		
Chronic skin problems?			Date of last dental exam?		
Excessive skin dryness?			Problems with teeth/dentures?		
Problems with "easy bruising"?			Frequent mouth ulcers/infections?		
Chemical or jewelry rash/sensitivity?			Sinus or hay fever?		
Neuro – Have you ever had or do you currently have:			Frequent sore throats?		
A psychiatric or emotional problem?			Frequent nose bleeds?		
Numbness/weakness/paralysis?			Trouble with thyroid?		
Dizziness or fainting spells?			Problems requiring radiation to the neck area?		
Severe/frequent or migraine headaches?			Lungs – Have you ever had or do you currently have:		
Head Injury, concussion, or skull fracture?			Asthma or wheezing?		
Neurological disorders?			Coughed up any blood?		
Seizures or blackouts?			Shortness of breath without apparent reason?		
Stroke?			TB or positive skin test for TB?		

Health History (continued) Please check “yes” or “no”. If “yes”, give details in REMARKS section.					
	Yes	No		Yes	No
Lungs (continued) – Have you ever had or do you currently have:			Yellow jaundice or hepatitis?		
Pneumonia or pleurisy?			Problems with your pancreas?		
Do you cough every day, especially in the morning?			Gallbladder disease?		
Pain or tightness in chest?			Kidneys – Have you ever had or do you currently have:		
More than three episodes of bronchitis in one year?			Bladder or kidney infections?		
Ever smoked tobacco in any form?			Kidney stones?		
Had a chest x-ray?			Burning or discomfort on urination?		
Heart – Have you ever had or do you currently have:			Hernia?		
Rheumatic fever or heart murmur?			Blood in urine?		
Heart disease?			Miscellaneous – Have you ever had or do you currently have:		
Treated for heart condition?			Diabetes or sugar in your blood?		
Unusually cold or bluish-colored hands or feet?			Cancer of any kind?		
High blood pressure? How is it treated?			Muscle-Skeletal: Have you ever had or do you currently have:		
Do you have a history of elevated cholesterol?			Arthritis, rheumatism, neck, back, or spine injury or disease?		
Anemia or any blood disease?			Been treated for a back problem?		
Phlebitis, varicose veins, or blood clots/poor circulation?			Recurrent stiffness or back pain?		
Pain with activity?			Bursitis, tendonitis?		
GI – Have you ever had or do you currently have:			Recurrent pulled muscles or sprains?		
Ulcers?			Hand/wrist injury or problem?		
Hiatal hernia?			Kip or knee injury or problem?		
Indigestion, pain, or unusual burning in stomach?			Ankle or foot injury or problem?		
Vomiting of blood?			Frostbite?		
Bloody/tarry bowel movements?			Job requiring heavy lifting or standing, or sitting for long periods of time?		
Colitis or nervous stomach?			Any broken bones?		

Health History (continued) Please check "yes" or "no". If "yes", give details in REMARKS section.					
	Yes	No		Yes	No
For Females Only: Have you ever had or do you currently have:			Work History: Have you ever:		
Menstrual irregularities?			Been restricted in your work or given "light duty" because of your health or injury?		
Recurrent problems of the female organs?			Left a job because of health problems?		
Breast masses or lumps?			Been injured on the job and treated by a doctor?		
Do you practice monthly breast self-exam?			Received compensation for an industrial injury or illness?		
Date of last pap smear?			Are you receiving any healthcare treatment (e.g. physical therapy, chiropractic, acupuncture, medical, etc.)?		
For Males Only: Have you ever had or do you currently have:			Been hospitalized in the last 5 years?		
Prostate or testicular problems?			Have you had any illness or injury that we have not asked you about?		
Breast tenderness, swelling, or lumps?					
Do you practice monthly testicular self-exam?					
General Lifestyle:					
Do you exercise three times per week? 30 – 40 minutes each time? Identify types of exercise.					
Are you more than 30% above your ideal weight?					
Have you received a tetanus booster in the last 10 years?					
Have you been immunized against hepatitis B? Date?					
Do you take any prescription medications? Please list.					
Are you currently taking any over-the-counter medications on a regular basis? Please list.					

Remarks: (Please List details from the Health History questionnaire)

Misrepresentation of this information can lead to dismissal from the LSU FETI Recruit Academy.

I certify that the above information is true and complete to the best of my knowledge. I hereby give _____ permission to release this health -related information to the Medical Director of LSU Fire and Emergency Training Institute or his/her designee.

Date: _____ Signature: _____

Modified NFPA Medical Examination Form
LSU FETI USE ONLY