Perth County Paramedic Services Health Questionnaire

The information collected in this form is solely for the purpose of obtaining information required under the Ambulance Act and is a condition of employment. **This information will only be used by the County of Perth and will not be released to other agencies.**

This area for Applicant Completion:

Name: _____ Sex: Male ☐ Female ☐

Date of Birth_____
(y/m/d)

Address: _____

City: _____ Province_____

Postal Code _____

Telephone Number: (_____) _____

Alternate Number (_____) _____

Email: _____

Applicant's Certificate and Release of Information

I certify that the foregoing information is to the best of my knowledge correct and I agree to this report and any future report derived from this information being given only to Perth County Paramedic Service. The fee for the completion of this form is the sole responsibility of the applicant and not the responsibility of the County of Perth.

Applicant's Signature: _____ Date: _____

Perth County Paramedic Services Health Questionnaire

The following 7 pages are for Physician Completion only:

Applicants First Name: _____ Last Name: _____

Health History:

To be completed by the examining Physician. **Yes** answers must be explained below in the space provided.

1. Diseases of the Senses (Deafness, Vertigo, Visual Deficiencies, etc.) Yes ☐ No ☐

2. Cardiovascular Disease Yes ☐ No ☐
(Heart Failure, Angina, Infarction, Embolism, Arrhythmia, Syncope, Surgery, etc.)

3. Respiratory Diseases (Asthma, Chronic Bronchitis, Emphysema, etc.) Yes ☐ No ☐

4. Disease of the Musculo-Skeletal System Yes ☐ No ☐
(Fracture(s) or Amputation, Arthritis, etc.)

5. Metabolic Diseases (Diabetes (+) (-), Hypoglycemia, Thyroid, etc.) Yes ☐ No ☐

6. Psychiatric Disorders/ Mental Health (PTSD, Psychoneurosis, Psychosis, etc.) Yes ☐ No ☐

7. Addiction (Alcohol, Sedatives, Tranquilizers, Narcotics, etc.) Yes ☐ No ☐

8. Other Diseases Yes ☐ No ☐
(Blackouts, Fainting Spells, Anemia, Cancer, Blood Dyscrasia, etc.)

9. Neurological Diseases Yes ☐ No ☐
(Seizures, Cerebrovascular Disease, Parkinson's disease,
Multiple Sclerosis, Dementia, Head Injury, Mental Retardation, etc.)

Date of First Seizure: _____ Date of Last Seizure: _____

History Details (include degree of decompensation, etc.)

_____
_____
_____
_____
_____
_____
_____

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Medications (including details of all medication prescribed and dosages)

_____
_____
_____
_____
_____

Medical Examination: **Date of Examination:** _____

Height: _____ Weight: _____

1. Eyes: R.E. L.E.

   Without Glasses 20/ 20/

   With Glasses 20/ 20/

   Horizontal Field of Vision Right Normal Restricted

   Left Normal Restricted

   Squint, disease or eye injury: _____
   Indicate type of test given: Snellen Other: _____

2. Hearing: Meets standards defined in the H.T.A. with or without a hearing aid. Yes ☐ No ☐

3. Heart: Apical Rate: _____ Rhythm: _____

   Murmurs: _____ Blood Pressure: _____

4. Locomotion: Upper Extremities: _____ Lower Extremities: _____

   Neck & Lumbar: _____

5. Chest & Abdomen:_____

6. Urinary: Urine Protein_____ Glucose_____

7. Diabetes: Yes ☐ * No ☐ Type: _____

*Treatment: Diet Alone: ☐ Oral Medication (amount per 24hrs.)_____

Insulin (amount per 24 hrs.) _____

8. Hypoglycemia: Frequency: _____
Circumstances: _____
Loss of Consciousness: _____
Decrease in Cognition, etc.:_____

9. Neurological: Gait & Stance: _____ Reflexes: _____
Tremor: _____ Coordination: _____

10. Mental Competence: _____ Judgement: _____

11. Evidence of Emotional Disorder:

Instability	Yes ☐ No ☐	Psychosis	Yes ☐ No ☐
Neurosis	Yes ☐ No ☐	Drug Habituation	Yes ☐ No ☐
Alcoholism	Yes ☐ No ☐		

Immunization Record:

1. Tuberculin Skin Test

Negative or Unknown Reaction: 2 step Test required prior to employment (within 3 months of hire date). *Must be completed before **MMR vaccine (or any live attenuated vaccine**) is given or **30 days after receiving a live attenuated vaccine.***

If step 1 is **negative** (0-9 mm. induration at 48-72 hours), do Step 2 in 7-21 days.

If either step 1 or 2 is **positive** (10 mm. Or more in duration @ 48-72 hours) evaluate as in A above.

	Date of Test	Dates Read	Induration (mm.) + -
STEP 1			
STEP 2			

If over one year since last Mantoux please give and document below

Mantoux: Date given_____ Date read_____

Result: _____ mm induration

Known Positive Reaction:

Date of **TB Test**: _____ Size (mm): _____
(y/m/d)

Evaluation: 1. Physical examination/symptom enquiry regarding **evidence of active disease**

2. Chest X-ray: Date: _____ Result: _____ (copy of x-ray report ***within 1 year***)

3. INH Prophylaxis: No ☐ Yes ☐ Dosage _____

Duration _____

2. Chicken Pox (Varicella)*: Immunization Date: _____
***Laboratory evidence of immunity is required** (attach copy of Lab report)

Immune YES ☐ NO ☐

3. Tetanus: (every 10 years) Immunization Date: _____

4. Diphtheria: (every 10 years) Immunization Date: _____

5. Polio: (Full Primary Series is required) Immunization Date: _____series was completed

OR

Date: _____ of last booster

6. Measles, Mumps, and Rubella*: Immunization Date: _____
***Laboratory evidence of immunity is required** for **each** disease, Red Measles, Mumps and Rubella. (Attach lab reports.)

7. Pertussis: Immunization Date: _____
(y/m/d)

8. Hepatitis B Vaccine*: Date 1st _____ Date 2nd _____ Date 3rd _____
***Laboratory evidence of immunity is required Attach copy of Lab Report**

9. Influenza: Date: _____ (Must be current year)
(y/m/d)

If immunizations not complete, an explanation is required:

_____
_____
_____
_____

*Yellow Immunization cards will not be accepted as proof of immunization.

Health Status Report – Communicable Diseases

This report is being requested in order to comply with the conditions of Ambulance Services Communicable Disease Standards which states each paramedic within the service is to be free from all communicable diseases as listed below. This form is to be completed by your general practitioner.

Taken from Ministry of Health and Long Term Care Emergency Services Branch, Ambulance Services Communicable Disease Standards Table 1 – Part B April 2000 (Revised October 2002).

This is to certify that _____ (Patient's full name)

To the best of my knowledge **IS FREE FROM** the following communicable diseases listed below / next page :

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	Free From	**NOT** Free From		Free From	**NOT** Free From
Acquired Immunodeficiency Syndrome (AIDS)			Measles		
Amebiasis			Menignitis, acute, i. bacterial		
Anthrax			ii. viral		
Botulism			iii. other		
Brucellosis			Meningococcal disease, invasive		
Campylobacter enteritis			Malaria		
Chancroid			Mumps		
Chicken Pox (Varicella)			Opthalmia Neonatorum		
Chlamydia trachomatis infections			Parathyphoid Fever		
Cholera			Pertussis (Whooping Cough)		
Cytomegalovirus Infection (Congenital)			Plague		
Diphtheria			Poliomyelitis (Acute)		
Encephalitis (Primary Viral)			Psittacosis/Ornithosis		
Food Poisoning, all causes			Q Fever		
Gastroenteritis			Rabies		
Giardiasis			Rubella		
Gonorrhea			Rubella (Congenital Syndrome)		
Group A Streptococcal Disease (invasive)			Salmonellosis		
Haemophilus Influenza B Disease (Invasive)			Shigellosis		
Hemmorrhagic Fevers including Ebola virus disease, Marburg Virus Disease, and other virual causes			Syphilis		
Viral Hepatitis including Hepatitis A, B, C and D (Delta Hepatitis)			Trichinosis		
Influenza			Tuberculosis		
Lassa Fever			Tularemia		
Legionellosis			Typhoid Fever		
Leprosy			Verotoxin producing E.Coli Infections		
Listeriosis			Yellow Fever		
Lyme Disease			Yersiniosis		

Notes (if applicable)

_____

_____

_____

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Applicant Name: _____

Physician's Name: _____

Physician's Address:_____

Family Physician ☐ or Certified Specialist in _____

How long has this person been your patient? _____

Based on today's examination, there are no medical or physical reasons that would prevent this person from safely fulfilling the duties of a paramedic in the province of Ontario.

Physicians Name_____

Physicians Signature_____