OKLAHOMA FIREFIGHTER PENSION & RETIREMENT SYSTEM
4545 N. Lincoln Blvd., Suite 265
Oklahoma City, Oklahoma 73105-3414
1-800-525-7461 405/522-4600 Fax(405) 522-4643

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 murmur; varicosities, deep leg pain (thrombophelibitis), 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 betweeen 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, hernias? 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 symptoms and 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
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
J. Urinalysis
K. Drug Screen

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 changes 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	OTHER EKG CHANGES	SYMPTOMS	
Sit _____					
Standing _____					
Hypervent.					
Minutes					
1 _____					STAGE 1
2 _____					1.7 MPH
3 _____					10% GRADE
4 _____					STAGE 2
5 _____					2.5 MPH
E 6 _____					12% GRADE
X 7 _____					STAGE 3
E 8 _____					3.4 MPH
R 9 _____					14% GRADE
C 10 _____					STAGE 4
I 11 _____					4.2 MPH
S 12 _____					16% GRADE
E 13 _____					STAGE 5
14 _____					5.0 MPH
15 _____					18% GRADE
16 _____					STAGE 6
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: _____ % OF MHR: _____

MAX. SYSTOLIC B.P. _____ ST: _____ DOUBLE PRODUCT _____

VO_2 _____ R-WAVES: PRE: _____ POST: _____ RST: _____

FUNCTIONAL AEROBIC IMPAIRMENT: _____

INTERPRETATION:

SPIROMETRY REPORT

PHYSICIAN _____ TEST # _____

Name: _____ Date: _____

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

Diagnosis: _____

_____ ASTHMA	_____ TUBERCULOSIS	HISTORY:
_____ BRONCHITIS	_____ HYPERTENSION	_____ MORNING COUGH
_____ EMPHYSEMA	_____ CHEST PAIN	_____ SPUTUM COLOR
_____ LUNG CANCER	_____ OTHER	_____ 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)			
$\frac{FEV_1}{FVC}$			

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 (medical 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: _____

_____

_____