



# Ute Pass Regional Ambulance District

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## Ute Pass Regional Ambulance Pre-Hire / Annual Medical Questionnaire

Note: This form is designated to provide the individual in charge of all personnel a complete history of physical status as of the date indicated without the need for expensive physical examinations. It is recommended that the form be completed on an annual basis by all drivers of emergency vehicles as well as other employees. If any of the questions are answered "Yes", by sure the answer is full explained.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City & State: \_\_\_\_\_ Zip: \_\_\_\_\_

Full Time Occupation: \_\_\_\_\_

Name of Organization: \_\_\_\_\_

Position / Title: \_\_\_\_\_

Social Security No. \_\_\_\_\_

What is your Valid State Operators Plate No. \_\_\_\_\_

(Note: If any question is answered "Yes", give particulars below. For medical histories, underline the item and identify by referring to question number and letter. Give dates, symptoms, duration, treatment results, names and addresses of doctors, hospitals, etc.)

1. Birth Date: Month \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

### 2. Eyesight:

- a. Have you lost use of either eye? \_\_\_\_\_ R \_\_\_\_\_ L.....a. Yes No
- b. Is peripheral (side) vision restricted?.....b. Yes No
- c. Are you color blind?.....c. Yes No
- d. Do you have, or ever had, cataracts?.....d. Yes No
- e. Are actual deficiencies corrected by glasses or contact lenses?.....e. Yes No
- f. Date of last eye examination:.....f. \_\_\_\_\_

### 3. Hearing:

- a. Do you have difficulty hearing normal conversation level?.....a. Yes No
- b. Do you use a hearing aid?.....b. Yes No

### 4. Diabetes:

- a. Have you ever been treated for diabetes?.....a. Yes No
- b. Describe current medications and dosage, if any, and method of administration under "remarks".
- c. Date of latest blood sugar test:.....c. \_\_\_\_\_

### Remarks:

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5. Heart:

- a. Have you ever been treated for heart disease?.....a. Yes No
- b. Describe condition:.....b. Yes No
- c. Describe current medication and dosage, if any, under "remarks".
- d. Do you have a pacemaker?.....d. Yes No
- e. Date of last treatment or check-up:.....e. Yes No

6. Epilepsy:

- a. Have you ever been treated for epilepsy?.....a. Yes No
- b. If "Yes", when was your last seizure?.....b. Yes No
- c. Describe current medications and dosage, if any, under "remarks".

7. Blood Pressure:

- a. Have you ever been treated for high blood pressure?.....a. Yes No
- b. If "Yes", when were you treated?.....b. Yes No
- c. What was your last reading?.....c, Yes No
- d. Describe current medication and dosage, if any, under "remarks".

8. Limbs:

- a. Have you lost an arm or leg?.....a. Yes No
- b. Have you lost the use of an arm or leg?.....b. Yes No
- c. Do you require special controls to operate a motor vehicle?.....c, Yes No
- d. If "Yes" to any of the above, describe under "remarks."

9. Miscellaneous:

- a. Have you ever had, or been treated for Convulsions?.....a. Yes No  
If "Yes", give date of last treatment and describe current medication and dosage, if any, under "remarks".
- b. Have you ever had Fainting Spells?.....b. Yes No  
If "Yes", give date of last treatment and describe current medication and dosage, if any, under "remarks".
- c. Have you ever had, or been treated for, Loss of Equilibrium?.....c. Yes No  
If "Yes", give date of last treatment and describe current medication and dosage, if any, under "remarks".
- d. Have you ever been treated for Alcohol or Drug Abuse?.....d, Yes No  
If "Yes", give date of last treatment and describe current medication and dosage, if any, under "remarks".
- e. Have you ever been treated for Mental Illness?.....e. Yes No  
If "Yes", give date of last treatment and describe current medication and dosage, if any, under "remarks".
- f. Have you ever had, or been treated for Back Pain / Injury / Problems or have any lifting restrictions?.....f. Yes No  
If "Yes", give date of last treatment and describe current medication and dosage, if any, under "remarks".

Remarks:

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10. What is the date of your last physical examination?.....

11. Are there any restrictions posted on your motor vehicle operators license?.....Yes No

12. Are you under the care of a physician for any condition, not mentioned above, which may affect your ability for operate a motor vehicle?.....Yes No

13. When, and for that purpose, did you last consult your doctor?

\_\_\_\_\_

14. Full name, address, and telephone number of your personal physician.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

The answers to the above are complete, accurate, and true to the best of my knowledge.

\_\_\_\_\_  
Signature of Person Named Above

\_\_\_\_\_  
Date

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***Authorization for Release***

“I hereby authorize any licensed physician, medical practitioner, hospital, or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of my or my health, to give \_\_\_\_\_ Operations Manager UPRAD any such information.”

A photographic copy, Xerox or similar reproduction or this authorization shall be as valid as the original.

\_\_\_\_\_  
Signature of Person Named Above

\_\_\_\_\_  
Date