JUSTICE INSTITUTE of BRITISH COLUMBIA

Fire & Safety Division
Health Questionnaire

715 McBride Boulevard
New Westminster, BC V3L 5T4
Tel. 604.528.5657 Fax. 604.528.5660

Please complete this form and bring it with you when you have your medical assessment.

LAST NAME:	FIRST NAME:	MIDDLE NAME:	DATE OF BIRTH: DD/MM/YY	SEX: M F
ADDRESS NUMBER:	STREET:	CITY:	PROVINCE:	POSTAL CODE:
TEL. WORK: AREA/NO.	TEL. HOME: AREA/NO.	DRIVERS' LICENSE NO.	SOCIAL INSURANCE NO.	PERSONAL HEALTH CARD NO.

✉Please answer all questions in INK before your medical appointment. Have you ever had, or do you have now, any of the following medical conditions? Check every item yes (🗐) or no (🗐) and if yes, state year, and in the space on the reverse side of this form please explain fully the nature of the condition, the treatment or surgery, and the name and address and telephone number of the specialist if any. In order to avoid delay in processing your application, please provide as many details as possible. Bring any available copies of operative or consultation reports that you have.

✉Please attach a copy of your recent optometrist's or ophthalmologist's report **(only if you have one).**

	Yes	Year	No		Yes	Year	No
1. GLASSES OR CONTACT LENS FOR READING, SURGERY				33. GAINED OR LOST WEIGHT IN LAST YEAR			
2. GLASSES OR CONTACT LENS FOR DISTANCE, SURGERY				34. FREQUENT INDIGESTION			
3. EYE TROUBLE OTHER THAN GLASSES				35. VOMITING OF BLOOD			
4. NOSE TROUBLE				36. ABDOMINAL PAIN			
5. SINUS TROUBLE				37. GALL BLADDER TROUBLE OR STONE			
6. HAY FEVER				38. JAUNDICE			
7. THROAT TROUBLE				39. LIVER TROUBLE			
8. RUNNING EAR				40. BOWEL TROUBLE			
9. RINGING IN THE EAR				41. COLITIS			
10. EAR TROUBLE				42. PILES (HAEMORRHOIDS)			
11. POOR HEARING				43. RECTAL TROUBLE			
12. MIGRANE HEADACHES				44. FREQUENT, PAINFUL OR NIGHT URINATION			
13. FREQUENT OR SEVERE HEADACHES				45. KIDNEY TROUBLE OR STONE			
14. HEAD INJURY				46. URINARY BLADDER TROUBLE			
15. SKULL FRACTURE/CONCUSSION				47. RUPTURE (HERNIA)			
16. DIZZY SPELLS/FAINTING/HYPOGLYCEMIA				48. PAINFUL OR SWOLLEN JOINTS			
17. EPILEPSY OR OTHER FITS				49. RHEUMATISM			
18. MENNINGITIS OR ENCEPHALITIS				50. ARTHRITIS			
19. A "STROKE"				51. A KNEE INJURY			
20. NERVOUS COMPLAINTS				52. SWELLING OF ANKLES			
21. THYROID COMPLAINTS				53. FOOT TROUBLE OR PAINFUL FEET			
22. PERSISTENT CHEST COUGH				54. BACK OR SPINAL INJURY			
23. LUNG DESEASE				55. BACK ACHE OR BACK TROUBLE			
24. SHORTNESS OF BREATH				56. SCIATICA			
25. TIGHTNESS OR PAIN IN CHEST				57. BROKEN BONES (FRACTURES)			
26. ASTHMA				58. DISLOCATED JOINT			
27. PNEUMONIA				59. SKIN TROUBLES OR RASHES			
28. PLEURISY				60. ALLERGIES			
29. TUBERCULOSIS				61. DIABETES			
30. PAIN AROUND HEART OR ANGINA				62. ANEMIA OR OTHER BLOOD DISEASE			
31. HEART TROUBLE OR HEART ATTACK				63. CANCER			
32. HIGH BLOOD PRESSURE				64. EMOTIONAL HEALTH PROBLEMS			
				65. PERMANENT DISABILITY FROM DISEASE OR INJURY			

PLEASE TURN OVER

Please give the name, address and telephone of your personal specialist(s), optometrist(s):

NAME	ADDRESS AND POSTAL CODE	TEL.: AREA/NO.	OP OR SPECIALIST

List below all operations, including <u>laser eye surgery</u>, you have had, and list all <u>Optometrists'</u> exminations and treatments including all contact lens treatments:

	YEAR		YEAR		YEAR
66.		68.		70.	
67.		69.		71.	

Please list below all work injuries in respect of which you have claimed, received or are receiving any compensation or disability pension, and state year:

	YEAR		YEAR		YEAR
72.		74.		76.	
73.		75.		77.	

78. DO YOU SMOKE CIGARETTES? IF YES, DAILY NUMBER ( ) ALCOHOL? AMOUNT/MONTH	☐ YES ☐ NO
79. HAVE YOU EVER SUFFERED ANY ILLNESS CAUSED BY THE NATURE OF YOUR WORK OR PLACE OF EMPLOYMENT?	☐ YES ☐ NO
80. HAVE YOU EVER BEEN REFUSED EMPLOYMENT BECAUSE OF YOUR HEALTH?	☐YES ☐ NO
81. DO YOU RECEIVE ANY DISABILITY PENSION FROM ANY SOURCE, E.G; D.V.A. WORKERS' COMPENSTAION, ETC.?	☐YES ☐ NO
82. IS THERE ANY FAMILY HISTORY OF DIABETES, EPILEPSY, MENTAL ILLNESS OR TUBERCULOSIS? HEART DISEASE OR STROKE?	☐YES ☐ NO
83. DO YOU HAVE ANY AILMENT CURRENTLY BEING TREATED BY A HEALTH PROFESSIONAL?	☐ YES ☐ NO
84. ARE YOU TAKING ANY DRUGS OR MEDICINES AT THE PRESENT TIME?	☐ YES ☐ NO
85. PLEASE DESCRIBE YOUR PRESENT STATE OF HEALTH	☐ YES ☐ NO

If any of the questions overleaf or above are answered yes, please explain full in this space:
The number of the question you are explaining is required. If space is insufficient then continue on a blank page please.

Your signature pertains to both the declaration and the authorization. Please read these carefully.
DECLARATION: I have read and clearly understand the questions in this health questionnaire and I hereby declare that the answers are complete, true and correct without misrepresentation.

AUTHORIZATION: I consent to undergo a complete medical examination by physician and to have laboratory tests as required. I authorize the release of any information contained herein when considered necessary in connection with my application for the Career Fire Fighter Pre-employment Certificate Program.

SIGNATURE:	FIRST NAME	DATE: (dd/mm/yy)