

ORANGE COUNTY FIRE AUTHORITY EXPLORING PROGRAM  
**MEDICAL EXAMINATION REPORT**

**Name:** \_\_\_\_\_  
Last First M.I.

*(To be completed by a licensed physician)*

Height: _____ Weight: _____	<b>VITAL SIGNS:</b> Blood Pressure: _____ Pulse: _____
<b>HEARING:</b> (Ordinary conversation at 20' considered normal) Right _____/20      Left _____/20 Hearing Aid Used:    No              Yes	<b>VISION:</b> Uncorrected:      Corrected: Right 20/____      Right 20/____      Glasses Left 20/____      Left 20/____      Contact Lenses
<b>HEAD:</b> (Eyes, ears, nose, mouth, throat)	<b>LUNGS:</b>
<b>HEART &amp; CIRCULATORY SYSTEM:</b>	<b>NERVOUS SYSTEM:</b>
<b>URINALYSIS:</b> SP. Gravity: Albumin: Sugar:	<b>RECTAL:</b> Fissures? Fistula? Hemorrhoids?
<b>GENITO-URINARY:</b>	<b>ABDOMEN, G-1 TRACT:</b> Hernia?
<b>SPINE:</b>	<b>EXTREMITIES:</b>
<b>SKIN:</b>	<b>VARICOSE VEINS:</b> (Severity)

<b>RECOMMENDATION &amp; COMMENTS:</b> Fit (no reservations) Fit for limited work (Please comment on any limitations of type or amount of activity suggested or recommended) Unfit (Please comment)
SIGNATURE OF EXAMINER: _____      DATE: _____
PRINTED NAME OF EXAMINER: ADDRESS: PHONE: