

DISTRICT #	DATE SUBMITTED (SCOMC USE ONLY)

## SCCFAIG Fire Department OSHA Respiratory/ Medical Evaluation QUESTIONNAIRE

All questions must be answered completely with a yes, no, none or not applicable. *Leave no questions blank.*

Employment Status: (Check all that apply) <input type="radio"/> New Hire <input type="radio"/> Renewal    Date of hire _____			
Date:		SSN:	
Last Name:		First Name:	MI:
Mailing Address:		City:	State:
Home Phone No:		Alternate Phone No:	Date of Birth:
E-mail Address:		Station Phone No:	Last Fit Test Date: (If any)
			Age:
			Zip Code:

**To the Employee/Applicant:**

**Do you require assistance with this form?** Yes  No

The medical questionnaire was developed by Cal OSHA and the SCCFAIG Fire Department Medical Consultant as part of the comprehensive medical evaluation process to determine fitness to use respiratory protection equipment within SCCFAIG Fire Department. It is important that this confidential medical questionnaire not be shared with co-workers, supervisors, or others not involved in the medical review process.

Your District supervisor must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your supervisor must tell you how to deliver or send this questionnaire to the health care professional who will review it. Neither your supervisor nor management may look at or review your answers.

**PART A – SECTION 1. The following information must be provided by every employee who is required to use any type of respirator (please print).**

1. **Sex** (Check one):  Male  Female  
**Race:**  Caucasian  African-American  Asian  Hispanic  Other \_\_\_\_\_
2. **Your height:** \_\_\_\_\_ Ft. \_\_\_\_\_ In.
3. **Your weight:** \_\_\_\_\_ lbs.
4. **Your current job title:**  
\_\_\_\_\_
5. Phone number where you can be reached between the hours of 8:30 am and 5:30 pm by the health care professional who reviews this questionnaire:  
(include area code)  
(     ) \_\_\_\_\_
6. The best time during the hours of 8:30 am and 5:30 pm to phone you at this number:  
(include area code)  
(     ) \_\_\_\_\_
7. **Has your supervisor told you how to contact the health care professional who will review this questionnaire?** Yes  No

8. **Check the type of respirator you will use (you can check more than one category):** Yes  No
- a. \_\_\_\_\_ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
- b. \_\_\_\_\_ Half- or full-face piece type.
- c. \_\_\_\_\_ Powered-air purifying, supplied-air.
- d. \_\_\_\_\_ Self-contained breathing apparatus.

9. **Have you worn a respirator (check one):** Yes  No
- If yes, what type(s):
- a. \_\_\_\_\_ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
- b. \_\_\_\_\_ Half- or full-face piece type.
- c. \_\_\_\_\_ Powered-air purifying, supplied-air.
- d. \_\_\_\_\_ Self-contained breathing apparatus.

**SECTION 2. (Please check applicable "YES" or "NO" box.)**

1. **Do you currently smoke tobacco, or have you smoked tobacco in the last month?** Yes  No

2. **Have you ever had any of the following conditions?**
- a. Seizures (fits). Yes  No
- b. Diabetes (sugar disease). Yes  No
- If yes please indicate:  Insulin Dependent  Non-insulin Dependent
- c. Allergic reactions that interfere with your breathing. Yes  No
- d. Claustrophobia (fear of closed-in places). Yes  No
- e. Trouble smelling odors? Yes  No

3. **Have you ever had any of the following pulmonary or lung problems?**
- a. Asbestosis. Yes  No
- b. Asthma. Yes  No
- c. Chronic bronchitis. Yes  No
- d. Emphysema. Yes  No
- e. Pneumonia. Yes  No
- f. Tuberculosis. Yes  No
- g. Silicosis. Yes  No
- h. Pneumothorax (collapsed lung). Yes  No
- i. Lung cancer. Yes  No
- j. Broken ribs. Yes  No
- k. Any chest injuries or chest surgeries. Yes  No
- l. Any other lung problem that you have been told about? Yes  No

4. **Do you currently have any of the following symptoms of pulmonary or lung illness?**
- a. Shortness of breath. Yes  No
- b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline. Yes  No
- c. Shortness of breath when walking with other people at an ordinary pace on level ground. Yes  No
- d. Have to stop for breath when walking at your own pace on level ground. Yes  No
- e. Shortness of breath when washing or dressing yourself. Yes  No
- f. Shortness of breath that interferes with your job. Yes  No
- g. Coughing that produces phlegm (thick sputum). Yes  No

- h. Coughing that wakes you early in the morning. Yes  No
- i. Coughing that occurs mostly when you are lying down. Yes  No
- j. Coughing up blood in the last month. Yes  No
- k. Wheezing. Yes  No
- l. Wheezing that interferes with your job. Yes  No
- m. Chest pain when you breathe deeply. Yes  No
- n. Any other symptoms that you think may be related to lung problems? Yes  No
- 5. Have you ever had any of the following cardiovascular or heart problems?**
- a. Heart attack. Yes  No
- b. Stroke. Yes  No
- c. Angina. Yes  No
- d. Heart failure. Yes  No
- e. Swelling in your legs or feet (not caused by walking). Yes  No
- f. Heart arrhythmia (heart beating irregularly). Yes  No
- g. High blood pressure. Yes  No
- h. Any other heart problem that you've been told about? Yes  No
- 6. Have you ever had any of the following cardiovascular or heart symptoms?**
- a. Frequent pain or tightness in your chest. Yes  No
- b. Pain or tightness in your chest during physical activity. Yes  No
- c. Pain or tightness in your chest that interferes with your job. Yes  No
- d. In the past two years, have you noticed your heart skipping or missing a beat. Yes  No
- e. Heartburn or indigestion that is not related to eating. Yes  No
- f. Any other symptoms that you think may be related to heart or circulation problems? Yes  No
- 7. Do you currently take medication for any of the following problems?**
- a. Breathing or lung problems. Yes  No
- b. Heart trouble. Yes  No
- c. Blood pressure. Yes  No
- d. Seizures (fits). Yes  No
- e. Psychiatric (depression/anxiety) medications. Yes  No
- f. other?: \_\_\_\_\_ Yes  No
- 8. Have you taken any prescription or over the counter medications in the last 12 months. If yes, list prescription/medication name and dosage.** Yes  No
- 9. If you have used a respirator, have you ever had any of the following problems? Check all that apply.** Yes  No
- a. Eye irritation. Yes  No
- b. Skin allergies or rashes. Yes  No
- c. Anxiety. Yes  No
- d. General weakness or fatigue. Yes  No
- e. Any other problem that interferes with your use of a respirator? Yes  No

10. Would you like to talk to the health care professional about your answers to this questionnaire? Yes  No
11. Have you ever lost vision in either eye (temporarily or permanently)? Yes  No
12. Do you currently have any of the following vision problems?
- a. Wear contact lenses. Yes  No
  - b. Wear glasses. Yes  No
  - c. Color blind. Yes  No
  - d. Any other eye or vision problem? Yes  No
13. Have you ever had an injury to your ears, including a broken eardrum? Yes  No
14. Do you currently have any of the following hearing problems?
- a. Difficulty hearing. Yes  No
  - b. Wear a hearing aid. Yes  No
  - c. Any other hearing or ear problem? Yes  No
15. Have you ever had a back injury? Yes  No
16. Do you currently have any of the following musculoskeletal problems?
- a. Weakness in any of your arms, hands, legs, or feet. Yes  No
  - b. Back pain. Yes  No
  - c. Difficulty moving your arms and legs. Yes  No
  - d. Pain or stiffness when you lean forward or backward at the waist. Yes  No
  - e. Difficulty moving your head up or down. Yes  No
  - f. Difficulty moving your head side to side. Yes  No
  - g. Difficulty bending at your knees. Yes  No
  - h. Difficulty squatting to the ground. Yes  No
  - i. Climbing a flight of stairs or a ladder carrying more than 25 lbs. Yes  No
  - j. Any other musculoskeletal problem? Yes  No
17. Have you had any surgical operations? If yes, list the type of surgery and when it was performed. Yes  No
- | <u>Type of surgery</u> | <u>Date of surgery</u> |
|------------------------|------------------------|
|                        |                        |
|                        |                        |
|                        |                        |
18. Have you ever suffered from a heat-related illness? If yes, please describe: Yes  No
19. Are you currently under a medical provider's care? Yes  No
20. Have you had any motor vehicle accidents with injuries? If yes, please describe. Yes  No

**21. Past Medical History (please indicate if you have or had any of the following)**

- Depression Yes  No
- Diabetes Mellitus Yes  No
- Bleeding Difficulties Yes  No
- Emphysema Yes  No
- Heart Disease Yes  No
- Hepatitis or other infection Disease Yes  No
- Diet Controlled Yes  No
- Arthritis (Type) \_\_\_\_\_ Yes  No
- Cancer (Type/Treatment) \_\_\_\_\_ Yes  No
- Other (Specify) \_\_\_\_\_ Yes  No

**22. Surgical history (please indicate any past or upcoming surgeries/medical procedures)**

Yes  No

Type of Surgery Year

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**23. Family History**

- Heart Disease Yes  No
- Diabetes Yes  No
- Stroke Yes  No
- Cancer Yes  No
- Other: \_\_\_\_\_

Father -Living /Deceased age \_\_\_\_\_ cause of death \_\_\_\_\_  
Mother -Living/Deceased age \_\_\_\_\_ cause of death \_\_\_\_\_  
Brothers # alive \_\_\_\_\_ # deceased \_\_\_\_\_ age \_\_\_\_\_ cause of death \_\_\_\_\_  
Sisters # alive \_\_\_\_\_ # deceased \_\_\_\_\_ age \_\_\_\_\_ cause of death \_\_\_\_\_

**24. Occupational History (please list past and current positions held)**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**25. With in the last year please indicate if any of the following apply:\***

- Grown facial hair/beard Yes  No
- Facial reconstruction surgery Yes  No
- Significant weight loss/gain (more then 25lbs) Yes  No

(\* If you answered yes to any of these questions please notify your department head; you may need to repeat your respiratory fit test.)

**PART B**

1. List medications/supplements/herbs you use on a regular basis (include over-the-counter medications):

\_\_\_\_\_  
\_\_\_\_\_

2. Have you ever had or been advised to have an exercise treadmill test? Yes  No   
If **yes**, when was the last treadmill done? \_\_\_\_\_  
Were you advised to restrict your activities based on the results? Yes  No

3. List **previous** occupations or activities which you believe may have exposed you to toxic substances (include items such as pertinent military service, pesticide application, mining activities, rock drilling, asbestos abatement, lead abatement, chemical exposure, etc.):

<u>Previous Occupation/Activities</u>	<u>Exposure</u>
_____	_____
_____	_____
_____	_____

4 List any **present** occupations, other than SCCFAIG County Fire Department or activities that you feel may expose you to toxic substances (mining, smelting metals, welding, painting, auto/motorcycle repair etc.): Yes  No

<u>Previous Occupation/Activities</u>	<u>Exposure</u>
_____	_____
_____	_____
_____	_____

5. Are you on a HAZMAT Team? Yes  No   
5a. When was your last medical clearance examination for HAZMAT work?  
Date: \_\_\_\_\_

**Final Questions**

Is there anything about your work or medical history that should be considered in determining your ability to perform your work activities including any condition(s) not specifically referred to in the preceding questions? If yes, please advise: Yes  No

\_\_\_\_\_

Do you consider yourself to be in perfect health and fully fit to perform the job for which you applied? Yes  No   
\* if your answer is no please explain:

\_\_\_\_\_

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**CERTIFICATION:** I certify that I have provided true and complete information concerning my health.  
*\*Failure to respond to the questions fully and accurately may lead to dismissal\**

EMPLOYEE'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**SOME APPLICANTS MAY REQUIRE ADDITIONAL TESTING REQUIRED BY THE OCCUPATIONAL HEALTH MEDICAL PROVIDER/PHYSICIAN.**

\_\_\_\_\_ **Initial**

# SCCFAIG COUNTY FIRE DEPARTMENT OSHA RESPIRATORY MEDICAL RECOMMENDATION

Applicant Name (Last)	(First)	(Middle)	Department Name
Applicant Address			Department Address
Position Title <b>Firefighter</b>	Applicant's Current Occupation		Department Contact Name and Number

**THE SECTION BELOW IS TO BE COMPLETED BY PHYSICIAN OR STAFF AFTER HEALTH QUESTIONNAIRE FORM IS COMPLETED**

**ADMINISTRATIVE USE ONLY**

PFT Results:	Normal	Abnormal
CXR Results:	Normal	Abnormal

**PLHCP RECOMMENDATION:**

I have reviewed Part A of the OSHA Respirator Medical Evaluation Questionnaire:  
 **with** the employee     **without** the employee

I recommend that a physical examination be performed:     **YES**     **NO**

Physician/PLHCP Signature:	Date:
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**THIS SECTION TO BE COMPLETED BY PHYSICIAN ONLY**

**RESPIRATOR FIT TEST**  
 Not performed at SCOMC

**RESULTS OF EXAMINATION:**  
 **Pass:** May Wear Respirator **Without** Restrictions  
 May Wear Respirator **With** Following Restrictions: \_\_\_\_\_  
 \_\_\_\_\_  
 **Unable to clear for any respirator use**

Return to Clinic on Expiration date or \_\_\_\_\_ at \_\_\_\_\_ am/pm

This Examination Expires in:     1 year     2 years     3 years

Physician/PLHCP Signature:	Date:
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