SCOMC
Santa Cruz Occupational Medical Center

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) ❍ **New Hire** ❍ **Renewal** **Date of hire** _____				
Date:	SSN:			
Last Name:	First Name:		MI:	Suffix:
Mailing Address:	City:	State:	Zip Code:	
Home Phone No:	Alternate Phone No:	Date of Birth:	Age:	
E-mail Address:	Station Phone No:	Last Fit Test Date: (If any)		

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. Yes ❍ No ❍
If yes, list prescription/medication name and dosage.

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 ❍

Type of surgery	Date of surgery

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.):**

Previous Occupation/Activities	Exposure

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 ❍

Previous Occupation/Activities	Exposure

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:

_____

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 **Firefighter**	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:

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: