HEALTH HISTORY

Disclosure of medical information will only be made with the consent of the employee or in accordance with the requirements of the Genetic Information Non Disclosure Act (GINA), including disclosure to supervisors and managers regarding necessary restrictions to the work or duties of the employee and any necessary accomodations and to first aid and safety personnel when appropriate.

EXAM DATE:		TYPE OF EXAM:		POSITION:	
EMPLOYER:	Franklin County Fire and EMS				
EMPLOYEE INFORMATION:					
NAME (LAST, FIRST, MIDDLE INITIAL):				AGE:	SEX:
DATE OF BIRTH:		PHONE#:		DRIVERS LICENSE#	
PHYSICIAN:				PHONE #:	
EMERGENCY CONTACT (RELATION):				PHONE #:	

HEALTH HISTORY - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE?

HEALTH HISTORY	YES/NO	IF "YES", give details
SURGERIES/OPERATIONS:		
On your back, arm, leg, or knee?		
To treat a hernia?		
To treat a varicose vein?		
Had other operations?		
Ever been hospitalized?		
Have a serious allergy?		
Had a bad reaction to any medication?		
Advised not to take any medications (i.e. aspirins)?		
SKIN:		
Hives/Eczema or rash?		
Chronic skin problems (i.e. slow to heal)?		
Excessive dry skin?		
Problems with "easy bruising"?		
Chemical or jewelry rash/sensitivity?		
NEURO:		
A psychiatric or emotional problem?		
Numbness/weakness/paralysis?		
Dizziness or fainting spells?		
Severe/frequent or migraine headache?		
Head injury, concussion, or skull fracture?		
Neurological disorder?		
Seizure or blackouts?		
Meningococcal Meningitis?		
Stroke?		
HEAD/NECK:		
Dental exam in the past 12 months?		Date of last exam
Recent problems with teeth/dentures?		
Frequent mouth ulcers/infections?		
Sinus or Hay Fever?		
Frequent sore throat or nose bleeds?		
Trouble with thyroid (i.e. taking thyroid medication)?		
Problem requiring radiation treatment to neck?		

NAME: DATE OF EXAM:

HEALTH HISTORY PAGE 2 - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE?

EYE/EAR:		IF "YES", give details
Hearing loss?		
Frequent ear infections?		
Ringing in the ears?		
Other ear problems?		
Glaucoma or Cataracts?		
Red eyes?		
Eye injury/vision loss?		
Other eye problems?		
Wear glasses/contacts?		
Had a vision screen in the past 12 months?		Date of last vision screen:
LUNGS:		
Asthma or wheezing?		
Coughed up any blood?		
Shortness of breath without apparent reason?		
TB or positive skin test for TB?		
Pneumonia or Pleurisy?		
Do you cough every day, especially in the morning?		
Pain or tightness in chest?		
More than three episodes of bronchitis in one year?		
SARS Coronavirus 2 that causes Covid-19?		
Ever smoked tobacco in any form?		# of Years: / Packs/day: / Quit when?
Had a chest x-ray?		Last x-ray:
Any other respiratory disease?		
HEART:		
Rheumatic Fever or Heart murmur?		
Heart disease?		
Treated for heart condition?		
Unusually cold or bluish colored hands/feet?		
High blood pressure/HTN? If yes, how treated?		
History of elevated cholesterol?		
Anemia or any blood disease?		
Phlebitis, Varicose Veins, blood clots/poor circulation?		
Chest pain with activity?		
GASTRO - INTESTINAL:		
Ulcer?		
Hiatal Hernia?		
Indigestion, pain, or unusual burning in stomach?		
Vomiting of blood?		
Bloody, tarry bowel movements?		
Colitis or Nervous Stomach?		
Yellow jaundice or Hepatitis?		
Problems with pancreas?		
Gallbladder disease?		

NAME: DATE OF EXAM:

HEALTH HISTORY PAGE 3 - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE?

KIDNEYS:		IF "YES", give details
Bladder or Kidney infections?		
Kidney Stones?		
Burning /discomfort/frequent urination?		
Hernia?		
Blood in urine?		
MUSCULAR/SKELETAL:		
Fibromyalgia?		
Arthritis?		
Rheumatism?		
Neck injury or disease?		
Back injury or disease?		
Been treated for back problems?		
Recurrent stiffness or back pain?		
Hand/wrist injury or problems?		
Hip/knee injury or problems?		
Ankle/foot injury or problems?		
Frostbite?		
Any broken bones?		
MISCELLANEOUS:		
Cancer: pancreatic, throat, colon, rectal, brain?		
Leukemia?		
Hepatitis?		
HIV (Human Immunodeficiency Virus)?		
Job requiring long period of heavy lifting/standing/sitting?		
FEMALES ONLY:		
Menstrual irregularities?		
Recurrent problems of the female organs?		
Breast masses or lumps?		
Have you ever had a mammogram?		
Had a PAP smear in the past 12 months?		Date of last PAP smear?
MALES ONLY:		
Prostate or testicular problems?		
Breast tenderness, swelling, or lumps?		

MEDICATIONS, ALLERGIES, IMMUNIZATIONS:					
Medication allergies?		List Medications allergic to:			
Tetanus booster < 10 years ago?				Flu shot in the past year?	
Immunized for Hepatitis B?				HPV vaccine?	
List prescription medications. If none, enter "None".					
List over the counter medications. If none, enter "None".					

NAME: DATE OF EXAM:

HEALTH HISTORY PAGE 4

General health?		Average red meat meals/week?		
Seatbelt use?		Average alcoholic drinks/beers per week?		
Average hrs. sleep?		Do you exercise three times per week at a moderate to high impact rate?		
Average daily meals?				
≥ 50% of ideal weight?		Do you exercise 30-40 minutes each time?		
List the types of exercise: If none, enter "None".				

WORK HISTORY: HAVE YOU BEEN, OR HAVE YOU?

WORK HISTORY I:		**IF "YES", give details**
Been restricted in your work or placed on "light duty" because of health or injury?		
Left a job because of health problems?		
Been injured on the job and treated by a doctor?		
Received compensation for an industrial injury/illness?		
Are you receiving any health care treatment (i.e. physician, therapy, chiropractic, acupuncture, medical, etc.)?		
Been hospitalized in the last five years?		
Any illness or injury we have not asked you about?		
WORK HISTORY II:		**IF "YES", give details**
Are you exposed to fumes on a regular basis?		
Are you exposed to loud noises frequently?		
Do you moonlight or have additional jobs?		

WORK HISTORY III: EXPOSURES- HAVE YOU EVER WORKED AROUND HAZARDOUS LOCATIONS? IF "YES", EXPLAIN.		
Chemical plant?		
Coke oven?		
Construction?		
Cotton, flax, or hemp mill?		
Electronics plant?		
Farm?		
Foundry?		
Hazardous waste?		
Hospital?		
Lumber mill?		
Metal production?		
Mine?		
Nuclear industry?		
Paper mill?		
Pharmaceutical?		
Plastics production?		
Pottery mill?		

NAME: DATE OF EXAM:

WORK HISTORY III: EXPOSURES- HAVE YOU EVER WORKED AROUND HAZARDOUS LOCATIONS? IF "YES", EXPLAIN.		
Refinery?		
Rubber processing plant?		
Sand pit or quarry?		
Service station?		
Shipyard?		
Smelter?		
WORK HISTORY IV: HAVE YOU EVER WORKED AROUND HAZARDOUS MATERIALS? IF "YES", EXPLAIN		
Benzene?		
Benzidine?		
Beryllium?		
BIS Chloromethyl Ether?		
Cadmium?		
Carbon Disulfide?		
Carbon Tetrachloride?		
Chlorine?		
Chlordane?		
Chromates?		
Chromic acid mist?		
Cutting oils?		
DDT?		
Dieldrin?		
Dioxin?		
Dust, coal?		
Dust, sandblasting?		
Dust, other?		
Ethyl Dibromide?		
Ethylene Oxide?		
Extreme heat or cold?		
Heptachlor?		
Hexachlorobenzene?		
Isocitrates (TDI, MDI)?		
Loud or continuous noise?		
Mercury?		
Methylene Chloride?		
Microwaves, lasers?		
Nickel?		
PCB's?		
Pesticides, herbicides?		
Pheons?		
Phosgene?		
Plastics?		
Radioactive materials?		
Roofing materials?		
Rubber?		
Silica?		

NAME: DATE OF EXAM:

WORK HISTORY IV: HAVE YOU EVER WORKED AROUND HAZARDOUS MATERIALS? IF "YES", EXPLAIN		
Solvents/degreasers?		
Soots/tars?		
Spray painting?		
TRI/PER Chloroethylene?		
Vinyl Chloride?		

SECOND JOBS: IF NONE, ENTER "NONE" IN BOTH FIELDS	
Date (year to year), employer	Position and work hazards for job

ITEMS YOU WOULD LIKE TO DISCUSS WITH PROVIDER: IF NONE, ENTER "NONE".
I certify that the above information is true and complete to the best of my knowledge, as of this date,

Signature: Date:

RESPIRATOR MEDICAL SURVEILLANCE EXAM

NAME:		SEX:			EXAM DATE:	
		AGE:				
EMPLOYER:	Franklin County Fire and EMS			PROPOSED JOB:		
TYPE OF EXAMINATION:						
I UNDERSTAND THAT THE HEALTH CARE PROVIDER THAT I SEE FOR THIS MEDICAL PHYSICAL IS THE ONE WHO WILL REVIEW THIS QUESTIONNAIRE.						
HAVE YOU EVER WORN A RESPIRATOR?						
IF YES, WHAT TYPE(S)? IF NONE, ENTER "NONE".						

CHECK THE TYPE OF RESPIRATOR YOU WILL USE (CAN BE MORE THAN ONE):

a.	X	N, R, or P disposable respirator (filter-mask, non-cartridge type only)
b.	X	Other type (Example: half-or-full facepiece type, powered-air purifying,supplied air,SCBA)

LEVEL OF WORK EFFORT: **STRENUOUS**	EXTENT OF USAGE: **DAILY BASIS**	LENGTH OF USE: **1-2 HOURS**

SPECIAL WORK CONSIDERATIONS: **HIGH PLACES, TEMPERATURE, HAZ-MAT PROTECTION ETC.**

MEDICAL HISTORY

As a career or voluteer firefighter you are selected to wear an SCBA, answering questions 1-15 is mandatory.

Select YES or NO from the drop down box

1.		Do you currently smoke tobacco, or have you smoked tobacco in the last month?	
2.		Have you ever had any of the following conditions?	
	a.	Seizures?	
	b.	Diabetes (sugar disease)?	
	c.	Allergic reactions that interfere with your breathing?	
	d.	Claustrophobia (fear of closed-in places)?	
	e.	Trouble smelling odors?	
3.		Have you ever had any of the following pulmonary or lung problems?	
	a.	Asbestosis?	
	b.	Asthma?	
	c.	Chronic bronchitis?	
	d.	Emphysema?	
	e.	Pneumonia?	
	f.	Tuberculosis?	
	g.	Silicosis?	
	h.	Pneumothorax (collapsed lung)?	
	i.	Lung cancer?	
	j.	Broken ribs?	
	k.	Any chest injuries or surgeries?	
	l.	Any other lung problem that you've been told about?	

NAME: DATE OF EXAM:

RESPIRATOR MEDICAL HISTORY - PAGE 2

4.	Do you currently have any of the following symptoms of pulmonary or lung disease?		
	a.	Shortness of breath?	
	b.	Shortness of breath when walking fast on level ground or walking up a slight hill or incline?	
	c.	Shortness of breath when walking with other people at an ordinary pace on level ground?	
	d.	Have to stop for a breath when walking at you own pace on level ground?	
	e.	Shortness of breath when washing or dressing yourself?	
	f.	Shortness of breath that interferes with your job?	
	g.	Coughing that produces phlegm (thick sputum)	
	h.	Coughing that wakes you early in the morning?	
	i.	Coughing that occurs mostly when you are lying down?	
	j.	Coughing up blood in the last month?	
	k.	Wheezing?	
	l.	Wheezing that interferes with your job?	
	m.	Chest pain when you breathe deeply?	
	n.	Any other symptoms that you think may be related to lung problems?	
5.	Have you ever had any of the following cardiovascular or heart problems?		
	a.	Heart attack?	
	b.	Stroke?	
	c.	Angina?	
	d.	Heart failure?	
	e.	Swelling in your legs or feet (not caused by walking)?	
	f.	Heart arrhythmia (heart beating irregularly)?	
	g.	High blood pressure?	
	h.	Any other heart problem that you've been told about?	
6.	Have you ever had any of the following cardiovascular or heart symptoms?		
	a.	Frequent pain or tightness in your chest?	
	b.	Pain or tightness in your chest during physical activity?	
	c.	Pain or tightness in your chest that interferes with your job?	
	d.	In the past two years, have you noticed your heart skipping or missing a beat?	
	e.	Heartburn or indigestion that is not related to eating?	
	f.	Any other symptoms that you think may be related to heart of circulation problems?	
7.	Do you currently take medication for any of the following problems?		
	a.	Breathing or lung problems?	
	b.	Heart trouble?	
	c.	Blood pressure?	
	d.	Seizures?	
8.	Have you used a respirator before? (If no, select N/A for conditions below)		
	If yes, have you had or do you have any of the conditions below?		
	a.	Eye irritation?	
	b.	Skin allergies or rashes?	

	c.	Anxiety?	
	d.	General weakness or fatigue?	
	e.	Any other problem that interferes with your use of a respirator?	

NAME: DATE OF EXAM:

RESPIRATOR MEDICAL HISTORY - PAGE 3

9.	Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?		
10.	Have you ever lost vision in either eye (temporarily or permanently)?		
11.	Do you currently have any of the following vision problems?		
	a.	Wear contact lenses?	
	b.	Wear glasses?	
	c.	Color blind?	
	d.	Any other eye or vision problem?	
12.	Have you ever had an injury to your ears, including a broken eardrum?		
13.	Do you currently have any of the following hearing problems?		
	a.	Difficulty hearing?	
	b.	Wear a hearing aid?	
	c.	Any other hearing or ear problem?	
14.	Have you ever had a back injury?		
15.	Do you currently have any of the following musculoskeletal problems?		
	a.	Weakness in any of your arms, hands, legs, or feet?	
	b.	Back pain?	
	c.	Difficulty fully moving your arms and legs?	
	d.	Pain and stiffness when you lean forward or backward at the waist?	
	e.	Difficulty fully moving your head up or down?	
	f.	Difficulty fully moving you head side to side?	
	g.	Difficulty bending at your knees?	
	h.	Difficulty squatting to the ground?	
	i.	Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.?	
	j.	Any other muscle or skeletal problem that interferes with using a respirator?	