

OCCUPATIONAL HEALTH SCREENING FORM

Reason for Visit:

Date:

Patient Information						
Name	DOB	DoD ID or Full SSN:				
Organization/Program		Job Title & Job Series				
Work Number		Cell Number:				
Email:	Supervisor:	Supervisor's Phone:				
Personal medical history (check all that apply)						
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; border-right: 1px solid black; padding-right: 10px;"> ☐ No known medical conditions ☐ Allergies (Drug, Food, Environmental) ☐ Anemia ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Autoimmune Disorder (Specify: _____) ☐ Cancer (Specify: _____) ☐ Congestive heart failure ☐ COPD / Emphysema ☐ Depression ☐ Diabetes (Type 1 / Type 2) ☐ Epilepsy / Seizures ☐ GERD (Acid Reflux) ☐ Glaucoma ☐ Gout </td> <td style="width: 50%; vertical-align: top; padding-left: 10px;"> ☐ Heart Attack / Heart Disease ☐ High Blood Pressure (Hypertension) ☐ High Cholesterol ☐ HIV/AIDS ☐ Kidney Disease / Kidney Stones ☐ Liver Disease / Hepatitis ☐ Migraines ☐ Osteoporosis ☐ Sleep Apnea ☐ Sleep: Insomnia/Difficulties ☐ Stroke ☐ Substance Abuse (Alcohol / Drugs) ☐ Thyroid Disease (Hypo / Hyper) ☐ Tuberculosis ☐ Ulcers </td> </tr> </table>					☐ No known medical conditions ☐ Allergies (Drug, Food, Environmental) ☐ Anemia ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Autoimmune Disorder (Specify: _____) ☐ Cancer (Specify: _____) ☐ Congestive heart failure ☐ COPD / Emphysema ☐ Depression ☐ Diabetes (Type 1 / Type 2) ☐ Epilepsy / Seizures ☐ GERD (Acid Reflux) ☐ Glaucoma ☐ Gout	☐ Heart Attack / Heart Disease ☐ High Blood Pressure (Hypertension) ☐ High Cholesterol ☐ HIV/AIDS ☐ Kidney Disease / Kidney Stones ☐ Liver Disease / Hepatitis ☐ Migraines ☐ Osteoporosis ☐ Sleep Apnea ☐ Sleep: Insomnia/Difficulties ☐ Stroke ☐ Substance Abuse (Alcohol / Drugs) ☐ Thyroid Disease (Hypo / Hyper) ☐ Tuberculosis ☐ Ulcers
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Other medical issues:						
Medications						
Name(s)	Dosage(s)	Frequency	Reason for Taking	Note(s)		
Medication Allergies/Reaction Name of Medication(s): ☐ No medication allergies Reaction(s):						
Allergy to Latex: Yes ☐ No ☐ If yes, reaction:						

Surgeries (site and date)		
Social history		
Factor	Check one	Most recent date (if applicable)
Tobacco Use	☐ Cigarettes ☐ Cigars ☐ Chew/Dip ☐ Vape ☐ Quit ☐ Never Used	
Alcohol Use	☐ Occasional ☐ Moderate ☐ Heavy ☐ Don't Drink	
Caffeine (Coffee, Tea, Soda, Energy Drinks)	☐ No ☐ Yes (amount per day)	
Pre/Post Workout Supplements	☐ No ☐ Yes [] Times per week	
Exercise Routine	[] Times per week	
Sleep	[] Hours a night	
Living Situation: ☐ With roommates ☐ With S/O ☐ With family ☐ Other:		
Additional Notes <i>By providing my name (full name: first and last), date of birth (DOB) and today's date, I hereby certify that, to the best of my knowledge, the above provided information is true and accurate.</i> Patient name: _____ DOB: _____ Date: _____		
Staff Section: Vitals: Height: _____ Weight: _____ BMI: _____ BP: _____ HR: _____ Resp: _____ Temp: _____ O2Sat: _____ Repeat vitals: Nurses Notes: Providers Notes:		

REPORT OF MEDICAL HISTORY (This information is for official and medically confidential use only and will not be released to unauthorized persons.)				OMB No. 0704-0413 OMB approval expires Oct 31, 2017	
The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Directives Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (0704-0413). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.					
PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.					
PRIVACY ACT STATEMENT					
AUTHORITY: 10 U.S.C. 136, DoD Instruction 6130.03, and E.O. 9397, as amended (SSN). PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted on the prescreening form (DD 2807-2). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted. Completed forms are covered by recruiting, medical evaluation board, and official military personnel file SORNs maintained by each of the Services. ROUTINE USE(S): The Blanket Routine Uses found at http://dpcl.dod.mil/Privacy/SORNsIndex/BlanketRoutineUses.aspx apply to this collection. DISCLOSURE: Voluntary. However, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.					
WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.					
1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)		2. SOCIAL SECURITY NUMBER		3. TODAY'S DATE (YYYYMMDD)	
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)		5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)			
b. HOME TELEPHONE (Include Area Code)		Fox Army Health Center 4100 Goss Road Redstone Arsenal, AL 35809-7000			
X ALL APPLICABLE BOXES:					7.a. POSITION (Title, Grade, Component)
6.a. SERVICE ☐ Army ☐ Coast Guard ☐ Navy ☐ Marine Corps ☐ Air Force		b. COMPONENT ☐ Regular ☐ Reserve ☐ National Guard		c. PURPOSE OF EXAMINATION ☐ Enlistment ☐ Medical Board ☐ Other (Specify) ☐ Commission ☐ Retirement ☐ Retention ☐ U.S. Service Academy ☐ Separation ☐ ROTC Scholarship Program	
8. CURRENT MEDICATIONS (Prescription and Over-the-counter)					b. USUAL OCCUPATION
9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)					
Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.					
HAVE YOU EVER HAD OR DO YOU NOW HAVE:				12. (Continued)	
10.a. Tuberculosis YES NO ☐ ☐				f. Foot trouble (e.g., pain, corns, bunions, etc.) YES NO ☐ ☐	
b. Lived with someone who had tuberculosis YES NO ☐ ☐				g. Impaired use of arms, legs, hands, or feet YES NO ☐ ☐	
c. Coughed up blood YES NO ☐ ☐				h. Swollen or painful joint(s) YES NO ☐ ☐	
d. Asthma or any breathing problems related to exercise, weather, pollens, etc. YES NO ☐ ☐				i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.) YES NO ☐ ☐	
e. Shortness of breath YES NO ☐ ☐				j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint YES NO ☐ ☐	
f. Bronchitis YES NO ☐ ☐				k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc. YES NO ☐ ☐	
g. Wheezing or problems with wheezing YES NO ☐ ☐				l. Bone, joint, or other deformity YES NO ☐ ☐	
h. Been prescribed or used an inhaler YES NO ☐ ☐				m. Plate(s), screw(s), rod(s) or pin(s) in any bone YES NO ☐ ☐	
i. A chronic cough or cough at night YES NO ☐ ☐				n. Broken bone(s) (cracked or fractured) YES NO ☐ ☐	
j. Sinusitis YES NO ☐ ☐				13.a. Frequent indigestion or heartburn YES NO ☐ ☐	
k. Hay fever YES NO ☐ ☐				b. Stomach, liver, intestinal trouble, or ulcer YES NO ☐ ☐	
l. Chronic or frequent colds YES NO ☐ ☐				c. Gall bladder trouble or gallstones YES NO ☐ ☐	
11.a. Severe tooth or gum trouble YES NO ☐ ☐				d. Jaundice or hepatitis (liver disease) YES NO ☐ ☐	
b. Thyroid trouble or goiter YES NO ☐ ☐				e. Rupture/hernia YES NO ☐ ☐	
c. Eye disorder or trouble YES NO ☐ ☐				f. Rectal disease, hemorrhoids or blood from the rectum YES NO ☐ ☐	
d. Ear, nose, or throat trouble YES NO ☐ ☐				g. Skin diseases (e.g. acne, eczema, psoriasis, etc.) YES NO ☐ ☐	
e. Loss of vision in either eye YES NO ☐ ☐				h. Frequent or painful urination YES NO ☐ ☐	
f. Worn contact lenses or glasses YES NO ☐ ☐				i. High or low blood sugar YES NO ☐ ☐	
g. A hearing loss or wear a hearing aid YES NO ☐ ☐				j. Kidney stone or blood in urine YES NO ☐ ☐	
h. Surgery to correct vision (RK, PRK, LASIK, etc.) YES NO ☐ ☐				k. Sugar or protein in urine YES NO ☐ ☐	
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.) YES NO ☐ ☐				l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.) YES NO ☐ ☐	
b. Arthritis, rheumatism, or bursitis YES NO ☐ ☐				14.a. Adverse reaction to serum, food, insect stings or medicine YES NO ☐ ☐	
c. Recurrent back pain or any back problem YES NO ☐ ☐				b. Recent unexplained gain or loss of weight YES NO ☐ ☐	
d. Numbness or tingling YES NO ☐ ☐				c. Currently in good health (If no, explain in Item 29 on Page 2.) YES NO ☐ ☐	
e. Loss of finger or toe YES NO ☐ ☐				d. Tumor, growth, cyst, or cancer YES NO ☐ ☐	

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER
Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.	
HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES NO
15.a. Dizziness or fainting spells	☐ YES ☐ NO
b. Frequent or severe headache	☐ YES ☐ NO
c. A head injury, memory loss or amnesia	☐ YES ☐ NO
d. Paralysis	☐ YES ☐ NO
e. Seizures, convulsions, epilepsy or fits	☐ YES ☐ NO
f. Car, train, sea, or air sickness	☐ YES ☐ NO
g. A period of unconsciousness or concussion	☐ YES ☐ NO
h. Meningitis, encephalitis, or other neurological problems	☐ YES ☐ NO
16.a. Rheumatic fever	☐ YES ☐ NO
b. Prolonged bleeding (<i>as after an injury or tooth extraction, etc.</i>)	☐ YES ☐ NO
c. Pain or pressure in the chest	☐ YES ☐ NO
d. Palpitation, pounding heart or abnormal heartbeat	☐ YES ☐ NO
e. Heart trouble or murmur	☐ YES ☐ NO
f. High or low blood pressure	☐ YES ☐ NO
17.a. Nervous trouble of any sort (<i>anxiety or panic attacks</i>)	☐ YES ☐ NO
b. Habitual stammering or stuttering	☐ YES ☐ NO
c. Loss of memory or amnesia, or neurological symptoms	☐ YES ☐ NO
d. Frequent trouble sleeping	☐ YES ☐ NO
e. Received counseling of any type	☐ YES ☐ NO
f. Depression or excessive worry	☐ YES ☐ NO
g. Been evaluated or treated for a mental condition	☐ YES ☐ NO
h. Attempted suicide	☐ YES ☐ NO
i. Used illegal drugs or abused prescription drugs	☐ YES ☐ NO
18. FEMALES ONLY. Have you ever had or do you now have:	☐ YES ☐ NO
a. Treatment for a gynecological (female) disorder	☐ YES ☐ NO
b. A change of menstrual pattern	☐ YES ☐ NO
c. Any abnormal PAP smears	☐ YES ☐ NO
d. First day of last menstrual period (YYYYMMDD)	☐ YES ☐ NO
e. Date of last PAP smear (YYYYMMDD)	☐ YES ☐ NO
19. Have you been refused employment or been unable to hold a job or stay in school because of:	☐ YES ☐ NO
a. Sensitivity to chemicals, dust, sunlight, etc.	☐ YES ☐ NO
b. Inability to perform certain motions	☐ YES ☐ NO
c. Inability to stand, sit, kneel, lie down, etc.	☐ YES ☐ NO
d. Other medical reasons (<i>If yes, give reasons.</i>)	☐ YES ☐ NO
20. Have you ever been treated in an Emergency Room? (<i>If yes, for what?</i>)	☐ YES ☐ NO
21. Have you ever been a patient in any type of hospital? (<i>If yes, specify when, where, why, and name of doctor and complete address of hospital.</i>)	☐ YES ☐ NO
22. Have you ever had, or have you been advised to have any operations or surgery? (<i>If yes, describe and give age at which occurred.</i>)	☐ YES ☐ NO
23. Have you ever had any illness or injury other than those already noted? (<i>If yes, specify when, where, and give details.</i>)	☐ YES ☐ NO
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (<i>If yes, give complete address of doctor, hospital, clinic, and details.</i>)	☐ YES ☐ NO
25. Have you ever been rejected for military service for any reason? (<i>If yes, give date and reason for rejection.</i>)	☐ YES ☐ NO
26. Have you ever been discharged from military service for any reason? (<i>If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.</i>)	☐ YES ☐ NO
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (<i>If yes, specify what kind, granted by whom, and what amount, when, why.</i>)	☐ YES ☐ NO
28. Have you ever been denied life insurance?	☐ YES ☐ NO
29. EXPLANATION OF "YES" ANSWER(S) (<i>Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.</i>)	

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

AUTHORITY: Public Law 104-191, Health Insurance Portability and Accountability Act of 1996; 10 U.S.C. Chapter 55, Medical and Dental Care; DoD Manual (DoDM) 6025.18, Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs; and E.O. 9397 (SSN).

PRINCIPAL PURPOSE(S): DD Form 2870 collects patient data and a patient's, or their parent's or legal representative's, authorization for a military treatment facility or dental treatment facility or DoD health plan to use or disclose an individual's protected health information.

ROUTINE USE(S): To third parties or individuals as per your written authorization.

APPLICABLE SORN: EDHA 07, Military Health Information System (June 15, 2020; 85 FR 36190). <https://dpclid.defense.gov/Portals/49/Documents/Privacy/SORNS/DHA/EDHA-07.pdf>

DISCLOSURE: Voluntary. If you choose not to provide your information, no penalty may be imposed and there will be a non-release of the protected health information. This form will not be used for authorization to disclose substance abuse information or treatment, if any, within your medical records nor will it be used to authorize the use or disclosure of psychotherapy notes, if any, within your medical records.

SECTION I - PATIENT DATA

1. NAME (Last, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. SOCIAL SECURITY NUMBER
4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD)	5. TYPE OF TREATMENT (X one) ☐ BOTH ☐ INPATIENT ☒ OUTPATIENT	

SECTION II - DISCLOSURE

6. I AUTHORIZE Fox Army Health Center Occupational Health Clinic (Name of Facility/TRICARE Health Plan)		TO RELEASE MY PATIENT INFORMATION TO:
a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION Hiring civilian Personnel Agency/Human Resources and/or Supervisory Personnel	b. ADDRESS (Street, City, State and ZIP Code) 4100 Goss Road Redstone Arsenal, AL 35809-7000	
c. TELEPHONE (Include Area Code)	d. FAX (Include Area Code)	
7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION (X as applicable) ☐ PERSONAL USE ☐ CONTINUED MEDICAL CARE ☐ SCHOOL ☒ OTHER (Specify) Pre-placement, Fit for duty, Medical qualification or Medical Surveillance exams ☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL		
8. INFORMATION TO BE RELEASED Copies of physical examination and supporting documentation (i.e. labs, test results, etc) related to physical and mental evaluation for physical year from authorization start date to authorization expiration date.		
9. AUTHORIZATION START DATE (YYYYMMDD)	10. AUTHORIZATION EXPIRATION ☐ DATE (YYYYMMDD) ☐ ACTION COMPLETED	

SECTION III - RELEASE AUTHORIZATION

I understand that:

a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.

b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR 164.524.ss

d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT (If applicable)	13. DATE (YYYYMMDD)
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SECTION IV - FOR STAFF USE ONLY (To be completed only upon receipt of written revocation)

14. X IF APPLICABLE: ☐ AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE (YYYYMMDD)
17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE Last name, First name: DOB: DoD ID#: Date:		SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:

Epworth Sleepiness Questionnaire

Name: _____ Today's date: _____

Date of Birth: _____ Last 4 SSN: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

It is important that you answer each question as best you can.

Situation	Chance of Dozing (0-3)
Sitting and reading	?
Watching TV	?
Sitting, inactive in a public place (e.g. a theatre or a meeting)	?
As a passenger in a car for an hour without a break	?
Lying down to rest in the afternoon when circumstances permit	?
Sitting and talking to someone	?
Sitting quietly after a lunch without alcohol	?
In a car, while stopped for a few minutes in the traffic	?
TOTAL SCORE:	0.00

Sleepiness Score: 0–10 Normal range for healthy adults; 11–14 Mild sleepiness; 15–17 Moderate sleepiness; 18 or higher Severe sleepiness

Fox Army Health Center

MCXW-OH

Hearing Program Questionnaire									
Last name			First name				DOB		
SSN			Phone				Rank/Grade		
MOS/Job code			Unit						
Branch/DoD (choose one)									
	Army		Navy		Coast Guard		Air Force		
	Marines		Cadet/ROTC		Civilian		Foreign National		
Service Component (choose one)									
	Active Duty			National Guard			Reserves		
Reason for Hearing Test (choose one)									
	Annual		Pre-employment		Pre-deployment		Retirement/ETS		
	Flight class		PCMH referral		Other:				
Are you bothered by ringing in the ears?									
	Not bothered at all			Bothered a little			Bothered a lot		
What type of hearing protection do you use?									
Do you wear hearing aids?									
Have you been exposed to loud noise within the last 14 hours?									
Have you returned from a deployment in the past 6 months?									
Any history of blast noise exposure?									
Any history of hearing loss?									
Have you seen an audiologist recently?									
Date of audiology appointment:									

Heat Stress Evaluation Questionnaire

Name: _____ DoD ID: _____

1. Have you had any heat related illnesses (heat fatigue, heat rash, heat syncope, heat cramps, heat exhaustion and/or heat stroke)?

☐ Yes ☐ No; if yes, when, what were you doing at the time and what was the outcome:

Definitions:

- a. Heat Fatigue- impaired performance of skilled sensorimotor, mental or vigilance jobs
- b. Heat Rash- "prickly heat" is red papules (bumps) that appear in areas where clothing is restrictive or the skin remains wet from un-evaporated sweat. Typically resolves when the individual returns to a cool environment.
- c. Heat Syncope- symptoms prior to brief loss of consciousness may include faintness, dizziness, headache, nausea, vomiting or restlessness.
- d. Heat Cramps- muscle cramps that develop after performing hard physical labor in a hot environment.
- e. Heat exhaustion- signs and symptoms include dizziness, fatigue, headache, nausea, weakness, unsteady walking, rapid pulse and shortness of breath.
- f. Heat stroke- occurs when the body's temperature regulation system fails and both temperature rises to critical levels, >104°F. Signs and symptoms include nausea, vomiting, confusion, irrational behavior, agitation, delirium, disorientation. Symptoms can progress to loss of consciousness, coma, convulsions and death. This is a medical emergency.

2. Current age: _____ (age greater than 65 are at increased risk for heat related illnesses).

3. How would you describe your general health?

☐ Excellent, ☐ Very Good ☐ Good, ☐ Fair, or ☐ Poor (patient at increased risk for heat related illnesses if in poor physical conditioning)

4. Have you had any of the following temporary medical conditions::

- a. Gastroenteritis (diarrhea and/or vomiting) in the past 24 hours?

☐ Yes ☐ No

- b. Sunburn in the past 48 hours that covered at least 50% of your body or was severe enough to compromise your oral fluid intake?

☐ Yes ☐ No

- c. Infection (Viral or Bacterial)?

☐ Yes ☐ No If yes, explain: _____

5. Do you have any of the following chronic medical conditions?

- a. Uncontrolled hypertension (systolic blood pressure > 160 or diastolic >100)?

☐ Yes ☐ No

- b. Cardiovascular disease (coronary artery disease and/or congestive heart failure)?

☐ Yes ☐ No

- c. Diabetes mellitus?

☐ Yes ☐ No

- d. Obesity (BMI > 30) (reduced skin area to mass ration): Current BMI: _____

6. Do you have or do you participate in any of the following activities/hobbies?

- a. Activities without adequate sleep? ☐ Yes ☐ No
 i. How many hours per sleep per night on average: _____
- b. Alcohol use (heavy consumption the night and/or weekend before work in heat stressful environment puts patient at increased risk for heat related illnesses):
☐ Yes ☐ No If yes, list type, quantity and frequency (i.e. beer 0-1 per day or hard liquor 2-3/week with 0-2 per day): _____
- c. Caffeine (heavy consumption): ☐ Yes ☐ No
 i. How many cups per day on average: _____
- d. Participation in sporting/exercise activities without adequate rest and rehydration prior to work in heat stressful environment: ☐ Yes ☐ No
- e. Body building (reduced skin area to mass ratio): ☐ Yes ☐ No
7. Do you smoke? ☐ Yes ☐ No If yes, what type, how much, how often and for how long (i.e. cigarettes 1.5 pk/day for the last 15 years): _____
8. List medications taking (prescribed and over the counter) or initial next to medication form attached:

<u>Medication</u>	<u>Drug or Drug Class</u>	<u>Proposed Mechanism of Action</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication form attached: _____

9. Have you been acclimatized to heat? ☐ Yes ☐ No

Heat acclimatization examples:

- a. New workers and those returning from a prolonged absence should begin with 20% of the workload on the first day, increasing incrementally by no more than 20% each subsequent day.
- b. During a rapid change leading to excessively hot weather or conditions such as a heat wave, even experienced workers should begin on the first day of work in excessive heat with 50% of the normal workload and time spent in the hot environment, 60% on the second day, 80% on day three, and 100% on the fourth day. Full acclimatization may take up to 14 days or longer depending on factors relating to the individual, such as increased risk of heat illness due to certain medications or medical conditions, or the environment.

Patient signature: _____

Date: _____

Reviewed by Provider: _____

Date: _____

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form see AR 40-66; the proponent agency is the Office of the Surgeon General

REPORT TITLE: Supplemental Medical History (continuation of DD form 2807-1) and Initial Occupational History for Chemical Workers

Answer each question by checking the appropriate box. Explain all YES answers in space provided at the end of the form.			
	YES	NO	Unsure
1. Have you ever taken corticosteroids (i.e. prednisone, prednisolone, etc.) for long periods of time?			
2. Have you had your spleen removed?			
3. Have you ever had chemotherapy or radiation therapy (such as for the treatment of cancer)?			
4. Have you ever had a condition that affects your immune system?			
5. Do you have a history of eczema, psoriasis, open sores, burns or any skin disorder?			
6. Have you ever been hospitalized for illness or injury?			
7. Have you ever had surgery?			
8. Have you ever undergone hypnosis (smoking cessation, weight control, etc.)?			
9. Are you or your spouse pregnant or planning a pregnancy?			
10. Have you developed an illness you think was job related?			
11. Have you changed your job or work assignment due to illness or injury?			
12. Have you ever worked with a substance that made your nose, chest or sinuses congested?			
13. Have you ever worked with a substance that irritated your skin or caused a skin rash?			
14. Have you ever worked with a substance that caused numbness, tingling or weakness?			
15. Do you have a second job?			
16. Have you experienced a change in your hearing due to work in a noisy environment (posted noise hazardous)?			
17. Have you experienced health problems related to exposure to vibration from your workplace (tools vehicles)?			
18. Have you ever had difficulty wearing/using respirator in you work?			
19. Have you ever worked with asbestos? (If yes, consider DD form 8493-1 or 2493-2)			
20. Have you ever worked in a setting (hospital, ambulance etc.) where you might have been exposed to biohazardous (blood, urine other body fluids) materials?			
21. Have you ever experienced pain from work that required repeated motion of a part of your body (wrist, knee, back)?			
22. Have you suffered health effects from working in dusty environments?			
23. Have you had skin sensitivity/allergies from wearing Latex gloves? (Complete Latex Questionnaire)			
24. Have you experienced difficulties in wearing encapsulating (Such as Level A or Level B) ensembles in your work?			
25. Have you ever had a job related injury?			
26. Do you have a disability rating (i.e. VA, State etc.)?			
27. Have you ever received disability Payments?			
28. Do you have any hobbies? If yes, please list			
29. Have you ever had work related exposures to cholinesterase inhibiting substances?			
30. Have you ever been told you were exposed to substances associated with cardiovascular (heart) disease?			
31. Have you ever been told you were exposed to substances associated with pulmonary (lung) disease?			
1			
REVIEWED BY (Signature & title)	Fox Army Health Center Redstone Arsenal, AL 35811	DATE (YYYYMMDD)	
PATIENT'S IDENTIFICATION <i>(For typed or written entries give: Name – last, First, middle; grade; date; hospital or medical facility)</i> Name: Grade: SSN: 20/ DOB: Facility: Fox Army Health Center/Redstone Arsenal	☒ HISTORY/PHYSICAL ☐ OTHER EXAMINATION OR EVALUATION ☐ DIAGNOSTIC STUDIES ☐ TREATMENT ☐ FLOW CHART ☐ OTHER <i>(Specify)</i> PAGE 1 OF 3		

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form see AR 40-66; the proponent agency is the Office of the Surgeon General

REPORT TITLE: Supplemental Medical History (continuation of DD form 2807-1) and Initial Occupational History for Chemical Workers

Answer each question by checking the appropriate box. Explain all YES answers in space provided at the end of the form.				YES	NO	Unsure
32. Have you ever been told you were exposed to a substance associated with neurological disease?						
33. Have you ever been told you were exposed to a substance associated with psychiatric disorders?						
34. Have you ever had exposures to mustard or lewisite?						
35. Have you ever had exposures to petroleum distillates?						
36. Have you ever had exposures to coal tar solvents?						
37. Have you ever had exposures to chlorinated hydrocarbons?						
38. Have you ever had exposures to alcohols?						
39. Have you ever had exposures to glycols?						
40. Have you ever had exposures to ketones?						
41. Have you ever had exposures to acetates?						
42. Have you ever had exposures to nickel?						
43. Have you ever had exposures to chromate?						
44. Have you ever had exposures to epoxy resins?						
45. Have you ever had exposures to phenolic resins?						
46. Have you ever had exposures to rubber antioxidants?						
47. Have you ever had exposures to biocides?						
48. Have you ever had exposures to organic dyes or amines?						
49. Have you had exposures to alkylating agents?						
50. Have you had exposures to developmental toxins?						
51. Have you ever had exposures to chemicals that affect the central nervous system?						
52. Have you ever had exposures to chemicals that affect the peripheral nervous system?						
53. Have you ever been involved in an alcohol related incident?						
54. Have you ever been referred to or sought counseling for alcohol or drug abuse?						
List past occupations in which you have had exposures that have not yet been addressed.						
Type of Job?	How long?	Exposures (use additional sheets If needed)				
REVIEWED BY (Signature & title)		Fox Army Health Center Redstone Arsenal, Alabama		DATE (YYYYMMDD)		
PATIENT'S IDENTIFICATION <i>(For typed or written entries give: Name – last, First, middle; grade; date; hospital or medical facility)</i> Name: Grade: SSN: 20/ DOB: Facility: Fox Army Health Center/Redstone Arsenal		☐ HISTORY/PHYSICAL ☐ OTHER EXAMINATION OR EVALUATION ☐ DIAGNOSTIC STUDIES ☐ TREATMENT ☐ FLOW CHART ☐ OTHER <i>(Specify)</i>				

PAGE 2 OF 3

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form see AR 40-66; the proponent agency is the Office of the Surgeon General

REPORT TITLE: Supplemental Medical History (continuation of DD form 2807-1) and Initial Occupational History for Chemical Workers

Employee's Comments on all Yes answers:

Employee's Signature: _____ Date: _____

PRP EMPLOYEE COMPLETE:

I understand that under the provisions of the PRP, I am required to report changes in my health (including medications and visits to any health care provider) to the Competent Medical Authority so that a determination about my medical reliability can be made. I further understand that failure to do so constitutes potentially disqualifying information (PDI) _____ (Initial)

Type or Print Employee Name	Signature	Date
-----------------------------	-----------	------

Type or Print Physician Name	Signature	Date
------------------------------	-----------	------

REVIEWED BY (Signature & title)	Fox Army Health Center Redstone Arsenal, Alabama	DATE (YYYYMMDD)
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PATIENT'S IDENTIFICATION (For typed or written entries give: Name – last, First, middle; grade; date; hospital or medical facility)

Name:

Grade:

SSN: 20/

DOB:

Facility: Fox Army Health Center/Redstone Arsenal

- | | |
|---|--|
| ☐ HISTORY/PHYSICAL | ☐ FLOW CHART |
| ☐ OTHER EXAMINATION
OR EVALUATION | ☐ OTHER (Specify) |
| ☐ DIAGNOSTIC STUDIES | |
| ☐ TREATMENT | PAGE 3 OF 3 |

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

This form is not an authorization or consent to use or disclose your health information.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):

10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. Chapter 55, Medical and Dental Care; 42 U.S.C. Chapter 32, Third Party Liability for Hospital and Medical Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); DoDI 6055.05, Occupational and Environmental Health (OEI); and E.O. 9397 (SSN), as amended.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED:

Information may be collected from you to provide and document your medical care; determine your eligibility for benefits and entitlements; adjudicate claims; determine whether a third party is responsible for the cost of Military Health System (MHS) provided healthcare and recover that cost; evaluate your fitness for duty and medical concerns which may have resulted from an occupational or environmental hazard; evaluate the MHS and its programs; and perform administrative tasks related to MHS operations and personnel readiness.

3. ROUTINE USES:

Information in your records may be disclosed to:

- Private physicians and Federal agencies, including the Department of Veterans Affairs, Health and Human Services, and Homeland Security (with regard to members of the Coast Guard), in connection with your medical care;
- Government agencies to determine your eligibility for benefits and entitlements;
- Government and nongovernment third parties to recover the cost of MHS provided care;
- Public health authorities to document and review occupational and environmental exposure data; and
- Government and nongovernment organizations to perform DoD-approved research.

Information in your records may be used for other lawful reasons which may include teaching, compiling statistical data, and evaluating the care rendered. Use and disclosure of your records outside of DoD may also occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: <http://dpcl.d.defense.gov/privacy/SORNsIndex/BlanketRoutineUses.aspx>.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION:

Voluntary. If you choose not to provide the requested information, comprehensive health care services may not be possible, you may experience administrative delays, and you may be rejected for service or an assignment. However, care will not be denied.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by MHS health care treatment personnel or for medical/dental treatment purposes and is intended to become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

5. SIGNATURE OF PATIENT OR SPONSOR

6. SOCIAL SECURITY NUMBER OR
DOD IDENTIFICATION NUMBER
OF MEMBER OR SPONSOR

7. DATE (YYYYMMDD)

INITIAL ENTRY TUBERCULOSIS (TB) RISK ASSESSMENT TOOL

For use of this form see, MEDCOM Reg 40-64, the proponent agency is MCPO-SA

INITIAL ENTRY Tuberculosis (TB) Risk Assessment Tool		REVIEWER INSTRUCTION
1. Have you ever had face-to-face contact with someone who was sick with tuberculosis (TB)?	☐ Yes ☐ No	
2. Were you born outside the United States? If yes, list country: _____	☐ Yes ☐ No	
3. Did you ever live with a family member that was born outside the United States? If yes, list country: _____	☐ Yes ☐ No	
4. Have you ever had a positive TB test, prior diagnosis of TB, or prior treatment for TB?	☐ Yes ☐ No	
If "NO" answers = low risk → STOP. Any "YES" answers = increase risk → Go to question #5		If all "NO" responses, Then do not test
5. Do you have any of the following symptoms of tuberculosis? Cough > 2 weeks, fever > 2 weeks, drenching night sweats, or unplanned weight loss?	☐ Yes ☐ No	
If "YES" → STOP. Any "NO" → Go to question #6		If "YES" then refer immediately to provider for evaluation of TB disease.
6. Do you have documentation of previous TB treatment with you today?	☐ Yes ☐ No STOP.	
Reviewer comments		If "YES" → Do NOT test. Document exemption in MEDPROS If "NO" → Test for TB. Note: If "Yes" response only to Question 2 or 3 above, testing is only required if the country is Listed on the reverse side.
PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last-first-middle; DOB; SSN; date; hospital or medical facility) NAME: DOB: DoD ID #: DATE:	REVIEWER NAME	REVIEWER SIGNATURE

The following countries, if documented on the TB Risk Assessment Tool, indicate need for patient to be tested:

Afghanistan	Egypt	Malaysia	Senegal
Algeria	El Salvador	Maldives	Serbia
Angola	Equatorial Guinea	Mali	Serbia & Montenegro
Anguilla	Eritrea	Marshall Islands	Seychelles
Argentina	Estonia	Mauritania	Sierra Leone
Armenia	Ethiopia	Mauritius	Singapore
Azerbaijan	Fiji	Micronesia – Fed States	Solomon Islands
Bahrain	French Polynesia	Moldova	Somalia
Bangladesh	Gabon	Mongolia	South Africa
Belarus	Gambia	Montenegro	Sri Lanka
Belize	Georgia	Montserrat	Sudan
Benin	Ghana	Morocco	Suriname
Bhutan	Guam	Mozambique	Swaziland
Bolivia	Guatemala	Myanmar	Syrian Arab Republic
Bosnia & Herzegovina	Guinea	N. Mariana Islands	Tajikistan
Botswana	Guinea – Bissau	Namibia	Tanzania-UR
Brazil	Guyana	Nauru	Thailand
British Virgin Islands	Haiti	Nepal	Timor-Leste
Brunei Darussalam	Honduras	New Caledonia	Togo
Bulgaria	India	Nicaragua	Tonga
Burkina Faso	Indonesia	Niger	Trinidad & Tobago
Burundi	Iran	Nigeria	Tunisia
Cambodia	Iraq	Pakistan	Turkey
Cameroon	Japan	Palau	Turkmenistan
Cape Verde	Kazakhstan	Panama	Turks & Caicos Islands
Central African Republic	Kenya	Papua New Guinea	Tuvalu
Chad	Kiribati	Paraguay	Uganda
China	Korea – DR	Peru	Ukraine
China, Hong Kong SAR	Korea – Rep of	Philippines	Uruguay
China, Macao SAR	Kuwait	Poland	Uzbekistan
Colombia	Kyrgyzstan	Portugal	Vanuatu
Comoros	Lao PDR	Qatar	Venezuela
Congo	Latvia	Romania	Viet Nam
Congo – DR	Lesotho	Russian Federation	Wallis & Futuna Islands
Cook Islands	Liberia	Rwanda	West Bank & Gaza Strip
Cote d'Ivoire	Libya	St. Vincent & Grenadines	Yemen
Croatia	Lithuania	Samoa	Zambia
Djibouti	Macedonia	Sao Tome & Principe	Zimbabwe
Dominican Republic	Madagascar	Saudi Arabia	
Ecuador	Malawi		

MEDICAL RECORD - OCCUPATIONAL HEALTH SURVEILLANCE FOR LATEX SENSITIVITY

For use of this form see MEDCOM Reg 40-44

DEPARTMENT	OCCUPATION	NUMBER OF YEARS IN OCCUPATION	WORK PHONE
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1. Has a doctor ever told you that you have an allergy to any latex products? ☐ Yes ☐ No

If YES, to what specifically did the doctor say you were allergic? _____

2. Do you have a history of : ☐ Contact Dermatitis ☐ Rhinitis or Conjunctivitis ☐ Eczema
☐ Spina Bifida ☐ Hay Fever ☐ Asthma
☐ Auto Immune Disease (i.e., thyroid disease, diabetes, lupus)

3. Please check product(s) to which you have a noted reaction:

☐ Surgical Gloves	☐ Enema Cuffs	☐ Rubber Bands/Binders	☐ Ostomy Bags
☐ Catheters	☐ Dental Darns	☐ Anesthetic Mask	☐ Intestinal Tubes
☐ Buretrols	☐ Condoms	☐ Rebreather Bags	☐ Ostomy Tubes
☐ Diaphragm	☐ Elastic Adhesives (bandaids)	☐ Powder in Latex	☐ Other _____
☐ Intubation Tubes	☐ Vial with Latex Tops	☐ Elastic Threads	
☐ Blood Pressure Cuffs	☐ Tubing (Latex Ports)	☐ Ballons	

4. Type of reaction noted:

☐ Sneezing	☐ Itchy Skin	☐ Chapped/Cracking Hands	☐ Stuffy Nose
☐ Low Blood Pressure	☐ Itchy Throat	☐ Shortness of Breath	☐ Runny Nose
☐ Wheezing	☐ Itchy Ears	☐ Lost of Consciousness	☐ Watery Eyes
☐ Tight Chest	☐ Itchy Eyes	☐ Rash	
☐ Other _____			

5. Do you have any food allergies? ☐ Yes ☐ No If YES, are you allergic to any of the following?

☐ Kiwi	☐ Banana	☐ Chestnut	☐ Avocado
☐ Passion Fruit	☐ Tomato	☐ Papaya	☐ Peaches
☐ Potato	☐ Milk	☐ Grape	☐ Other _____

6. Have you had any previous surgery? ☐ Yes ☐ No If YES, how many? _____

What types? _____

7. Have you ever had any allergic or unusual symptoms following a dental, gynecological, or rectal procedures? ☐ Yes ☐ No

If YES, explain: _____

8. Have you ever had hives, asthma, swelling and tightness in the throat or other unusual reaction to latex products or devices? ☐ Yes ☐ No

If YES, explain: _____

Comments: _____

REVIEWED BY (Signature and Title)	DEPARTMENT/SERVICE/CLINIC	DATE
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PATIENT IDENTIFICATION Name: _____ DOB: _____ SSN: _____ Date: _____ Facility: Fox Army Health Center	<table style="width: 100%;"><tr><td>☐ HISTORY/PHYSICAL</td><td>☐ FLOW CHART</td></tr><tr><td>☐ OTHER EXAMINATION OR EVALUATION</td><td>☐ OTHER (Specify) _____</td></tr><tr><td>☐ DIAGNOSTIC STUDIES</td><td>_____</td></tr><tr><td>☐ TREATMENT</td><td>_____</td></tr></table>	☐ HISTORY/PHYSICAL	☐ FLOW CHART	☐ OTHER EXAMINATION OR EVALUATION	☐ OTHER (Specify) _____	☐ DIAGNOSTIC STUDIES	_____	☐ TREATMENT	_____
☐ HISTORY/PHYSICAL	☐ FLOW CHART								
☐ OTHER EXAMINATION OR EVALUATION	☐ OTHER (Specify) _____								
☐ DIAGNOSTIC STUDIES	_____								
☐ TREATMENT	_____								

Medication Form

Medication Name

Dosage

How Often

Reason Taking

[illegible]

Last Name, First Name: _____

Full SSN: _____

DOB: _____

**FOX ARMY HEALTH CENTER
OCCUPATIONAL MEDICINE**

**OSHA Respirator Medical Evaluation Questionnaire
(Mandatory)**

SSN: _____ / _____ / _____

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee:

Can you read? (select one):

Yes ☐ No ☐

Your employer 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 employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print). Today's date _____

Name _____

Male/ Female

Job Title _____

Age _____

(circle one)

Height (ft, in) _____

Weight (lbs) _____

A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):

The best time to phone you at this number:

Has your employer told you how to contact the health care professional who will review this questionnaire (select one):

Yes ☐ No ☐

Check the type of respirator you will use (you can check more than one category):

a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only). b. _____ Other type ☐ half- face ☐ full-facepiece type,	☐ powered-air purifying, ☐ supplied-air, ☐ self-contained breathing apparatus.
--	---

Have you worn a respirator (select one):

Yes ☐ No ☐

If "yes," what type(s): _____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please select "yes" or "no").

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?

Seizures (fits)	Yes ☐	No ☐
Diabetes (sugar disease)	Yes ☐	No ☐
Allergic reactions that interfere with your breathing	Yes ☐	No ☐
Claustrophobia (fear of closed-in places)	Yes ☐	No ☐
Trouble smelling odors	Yes ☐	No ☐

3. Have you ever had any of the following pulmonary or lung problems?

Asbestosis	Yes ☐	No ☐
Asthma	Yes ☐	No ☐
Chronic bronchitis:	Yes ☐	No ☐
Emphysema:	Yes ☐	No ☐
Pneumonia	Yes ☐	No ☐
Tuberculosis	Yes ☐	No ☐
Silicosis	Yes ☐	No ☐
Pneumothorax (collapsed lung)	Yes ☐	No ☐
Lung cancer	Yes ☐	No ☐
Broken ribs:	Yes ☐	No ☐
Any chest injuries or surgeries:	Yes ☐	No ☐
Any other lung problem that you've been told about:	Yes ☐	No ☐

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

Shortness of breath:	Yes ☐	No ☐
Shortness of breath when walking fast on level ground or walking up a slight hill or incline	Yes ☐	No ☐
Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes ☐	No ☐
Have to stop for breath when walking at your own pace on level ground:	Yes ☐	No ☐
Shortness of breath when washing or dressing yourself:	Yes ☐	No ☐
Shortness of breath that interferes with your job:	Yes ☐	No ☐
Coughing that produces phlegm (thick sputum):	Yes ☐	No ☐
Coughing that wakes you early in the morning:	Yes ☐	No ☐
Coughing that occurs mostly when you are lying down:	Yes ☐	No ☐
Coughing up blood in the last month:	Yes ☐	No ☐
Wheezing:	Yes ☐	No ☐
Wheezing that interferes with your job:	Yes ☐	No ☐
Chest pain when you breathe deeply:	Yes ☐	No ☐
Any other symptoms that you think may be related to lung	Yes ☐	No ☐

5. Have you ever had any of the following cardiovascular or heart problems?

Heart attack	Yes ☐	No ☐
Stroke:	Yes ☐	No ☐
Angina:	Yes ☐	No ☐
Heart failure:	Yes ☐	No ☐
Swelling in your legs or feet (not caused by walking):	Yes ☐	No ☐
Heart arrhythmia (heart beating irregularly):	Yes ☐	No ☐
High blood pressure:	Yes ☐	No ☐
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?

Frequent pain or tightness in your chest	Yes ☐	No ☐
Pain or tightness in your chest during physical activity	Yes ☐	No ☐
Pain or tightness in your chest that interferes with your job	Yes ☐	No ☐
In the past two years, have you noticed your heart skipping or missing a beat :	Yes ☐	No ☐
Heartburn or symptoms that is not related to eating	Yes ☐	No ☐
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?

Breathing or lung problems:

Yes ☐ No ☐

Heart trouble:

Yes ☐ No ☐

Blood pressure:

Yes ☐ No ☐

Seizures (fits):

Yes ☐ No ☐

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9)

Eye irritation:

Yes ☐ No ☐

Skin allergies or rashes:

Yes ☐ No ☐

Anxiety:

Yes ☐ No ☐

General weakness or fatigue:

Yes ☐ No ☐

Any other problem that interferes with your use of a respirator:

Yes ☐ No ☐

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire:

Yes ☐ No ☐

Questions 10-15 below must be answered by every employee who has been selected to use either a *full-facepiece* respirator or a *self-contained breathing apparatus (SCBA)*. For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you ever lost vision in either eye (temporarily or permanently):

Yes ☐ No ☐

11. Do you currently have any of the following vision problems?

Wear contact lenses:

Yes ☐ No ☐

Wear glasses:

Yes ☐ No ☐

Color blind:

Yes ☐ No ☐

Any other eye or vision problem:

Yes ☐ No ☐

12. Have you ever had an injury to your ears, including a broken ear drum:

Yes ☐ No ☐

13. Do you currently have any of the following hearing problems?

Difficulty hearing:

Yes ☐ No ☐

Wear a hearing aid:

Yes ☐ No ☐

Any other hearing or ear problem:

Yes ☐ No ☐

14. Have you ever had a back injury:

Yes ☐ No ☐

15. Do you currently have any of the following musculoskeletal problems?

Weakness in any of your arms, hands, legs, or feet:

Yes ☐ No ☐

Back pain:

Yes ☐ No ☐

Difficulty fully moving your arms and legs:

Yes ☐ No ☐

Pain or stiffness when you lean forward or backward at the waist:

Yes ☐ No ☐

Difficulty fully moving your head up or down:

Yes ☐ No ☐

Difficulty fully moving your head side to side:

Yes ☐ No ☐

Difficulty bending at your knees:

Yes ☐ No ☐

Difficulty squatting to the ground:

Yes ☐ No ☐

Climbing a flight of stairs or a ladder carrying more than 25 lbs:

Yes ☐ No ☐

Any other muscle or skeletal problem that interferes with using a respirator:

Yes ☐ No ☐

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes ☐ No ☐

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes ☐ No ☐

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes ☐ No ☐

If "yes," name the chemicals if you know them: _____

Have you ever worked with any of the materials, or under any of the conditions, listed below:

Substance/Conditions	Description of exposure (only if answer is yes)	
Asbestos	Yes ☐	No ☐
Silica (e.g., in sandblasting)	Yes ☐	No ☐
Tungsten/cobalt (e.g., grinding or welding this material)	Yes ☐	No ☐
Beryllium:	Yes ☐	No ☐
Aluminum	Yes ☐	No ☐
Coal (for example, mining)	Yes ☐	No ☐
Iron:	Yes ☐	No ☐
Tin:	Yes ☐	No ☐
Dusty environments:	Yes ☐	No ☐
Any other hazardous exposures:	Yes ☐	No ☐

4. List any second jobs or side businesses you have: _____

5. List your previous occupations: _____

6. List your current and previous hobbies: _____

7. Have you been in the military services? Yes ☐ No ☐

If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes ☐ No ☐

8. Have you ever worked on a HAZMAT team? Yes ☐ No ☐

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes ☐ No ☐

If "yes," name the medications if you know them: _____

10. Will you be using any of the following items with your respirator(s)?

HEPA Filters:

Yes ☐ No ☐

b. Canisters (for example, gas masks):

Yes ☐ No ☐

c. Cartridges:

Yes ☐ No ☐

11. How often are you expected to use the respirator(s) (select "yes" or "no" for all answers that apply to you)?:

a. Escape only (no rescue):

Yes ☐ No ☐

b. Emergency rescue only:

Yes ☐ No ☐

c. Less than 5 hours per week:

Yes ☐ No ☐

d. Less than 2 hours per day:

Yes ☐ No ☐

e. 2 to 4 hours per day:

Yes ☐ No ☐

f. Over 4 hours per day:

Yes ☐ No ☐

12. During the period you are using the respirator(s), is your work effort:

Light (less than 200 kcal per hour):

Yes ☐ No ☐

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines

Moderate (200 to 350 kcal per hour):

Yes ☐ No ☐

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

Heavy (above 350 kcal per hour):

Yes ☐ No ☐

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes ☐ No ☐

If "yes," describe this protective clothing and/or equipment: _____

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes ☐ No ☐

15. Will you be working under humid conditions:

Yes ☐ No ☐

16. Describe the work you'll be doing while you're using your respirator(s): _____

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s)
(for example, confined spaces, life-threatening gases):

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when
you're using your respirator(s):

Name of Toxic Substance	Estimated maximum Exposure level per shift	Duration of exposure per shift

The name of any other toxic substances that you'll be exposed to while using your respirator:

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety
and well-being of others (for example, rescue, security):

To the best of my knowledge, the information I have provided is true and accurate.

Employee Name

Date

Employee Signature

Employee name: _____ Age _____ Sex _____ Date of birth: _____

Agency: _____ Work location: _____ Job title: _____

Supervisor's name: _____ Supervisor's phone: _____ fax: _____

Type of respirator use requested: ___ disposable, ___ negative pressure (cartridge), ___ PAPR, ___ airline, ___ SCBA

I. Basis for recommendations on respirator clearance:

Recommendations below on medical clearance for respirator use are based on a review of (check all that apply):

- ☐ Mandatory OSHA Respirator Medical Evaluation Questionnaire
- ☐ Records of a medical examination, including physical exam, done on: _____
- ☐ Additional information supplied by employee's personal physician.
- ☐ Other information (specify): _____

II. Recommendations on medical clearance for respirator use: (Choose A, B or C below)

- ☐ **A. The employee is given medical clearance to use the following respirator(s) under the conditions noted (choose all that apply)**

☐ N, R or P disposable respirator (filter-mask, non-cartridge type only)	☐ Supplied air (air line) respirator
☐ Negative pressure air-purifying (cartridge) respirator -- either half- or full-face	☐ Self-contained breathing apparatus (SCBA)
☐ Powered air purifying respirator (PAPR) -- either half or full face	

When using respirators, the employee is approved to perform the following (choose one)

- ☐ Mild exertion /low heat stress
- ☐ Moderate exertion
- ☐ Heavy exertion
- ☐ Escape only
- ☐ Normal job duties
- ☐ Other Activity _____

Mild exertion (2-3 mets) e.g. lifting up to 10 lbs, extended walking on a flat surface, extended standing

Moderate exertion (4-5 mets) e.g. lifting 10 lbs, 5 lifts per min, fast walking (4 mph), gardening/digging, pushing, pulling

Heavy exertion (5-10 mets) e.g. jogging (10 min/mi), chopping wood, climbing hills, life-saving activities, fire fighting

This respirator clearance expires (select one) _____ years from the date below (If not marked, clearance expires in 1 year)

- ☐ **B. The employee is not given medical clearance for respirator use because more information is needed (Specify what is needed to make a decision)**

- ☐ 1. A medical examination, including a physical exam*, is needed to make a decision*

*- Please use the FOH Medical Surveillance Health History and Physical Evaluation forms for this

- ☐ 2. The following additional information is needed for review (specify what): _____

- ☐ **C. The employee is not given medical clearance for respirator use because of the health problems as noted below (choose one below)**

- ☐ 1. A temporary health problem (which should be reevaluated in _____ months)
- ☐ 2. A health problem that appears permanent (routine re-evaluation is not needed)

Examiner / Reviewer Name (Print) _____

Phone number for questions _____

Examiner / Reviewer Signature _____

Date: _____