

# OCCUPATIONAL HEALTH SCREENING FORM

**Reason for Visit:**

**Date:**

| Patient Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |             |                        |                     |         |
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| 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)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |             |                        |                     |         |
| <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> No known medical conditions<br/> <input type="checkbox"/> Allergies (Drug, Food, Environmental)<br/> <input type="checkbox"/> Anemia<br/> <input type="checkbox"/> Anxiety<br/> <input type="checkbox"/> Arthritis<br/> <input type="checkbox"/> Asthma<br/> <input type="checkbox"/> Autoimmune Disorder (Specify: _____)<br/> <input type="checkbox"/> Cancer (Specify: _____)<br/> <input type="checkbox"/> Congestive heart failure<br/> <input type="checkbox"/> COPD / Emphysema<br/> <input type="checkbox"/> Depression<br/> <input type="checkbox"/> Diabetes (Type 1 / Type 2)<br/> <input type="checkbox"/> Epilepsy / Seizures<br/> <input type="checkbox"/> GERD (Acid Reflux)<br/> <input type="checkbox"/> Glaucoma<br/> <input type="checkbox"/> Gout             </div> <div style="width: 50%;"> <input type="checkbox"/> Heart Attack / Heart Disease<br/> <input type="checkbox"/> High Blood Pressure (Hypertension)<br/> <input type="checkbox"/> High Cholesterol<br/> <input type="checkbox"/> HIV/AIDS<br/> <input type="checkbox"/> Kidney Disease / Kidney Stones<br/> <input type="checkbox"/> Liver Disease / Hepatitis<br/> <input type="checkbox"/> Migraines<br/> <input type="checkbox"/> Osteoporosis<br/> <input type="checkbox"/> Sleep Apnea<br/> <input type="checkbox"/> Sleep: Insomnia/Difficulties<br/> <input type="checkbox"/> Stroke<br/> <input type="checkbox"/> Substance Abuse (Alcohol / Drugs)<br/> <input type="checkbox"/> Thyroid Disease (Hypo / Hyper)<br/> <input type="checkbox"/> Tuberculosis<br/> <input type="checkbox"/> Ulcers             </div> </div> |             |                        |                     |         |
| Other medical issues:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |             |                        |                     |         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |             |                        |                     |         |
| Medications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |             |                        |                     |         |
| Name(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Dosage(s)   | Frequency              | Reason for Taking   | Note(s) |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |             |                        |                     |         |
| Medication Allergies/Reaction    Name of Medication(s):<br><input type="checkbox"/> No medication allergies    Reaction(s):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |             |                        |                     |         |
| Allergy to Latex:    Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, reaction:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |             |                        |                     |         |

| Surgeries (site and date)                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                       |                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                       |                                                    |
| Social history                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                       |                                                    |
| Factor                                                                                                                                                                                                                                                                                                                          | Check one                                                                                                                                                                                             | Most recent date<br><small>(if applicable)</small> |
| Tobacco Use                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Chew/Dip <input type="checkbox"/> Vape <input type="checkbox"/> Quit <input type="checkbox"/> Never Used |                                                    |
| Alcohol Use                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> Don't Drink                                                             |                                                    |
| Caffeine (Coffee, Tea, Soda, Energy Drinks)                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> No <input type="checkbox"/> Yes (amount per day)                                                                                                                             |                                                    |
| Pre/Post Workout Supplements                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> No <input type="checkbox"/> Yes [   ] Times per week                                                                                                                         |                                                    |
| Exercise Routine                                                                                                                                                                                                                                                                                                                | [   ] Times per week                                                                                                                                                                                  |                                                    |
| Sleep                                                                                                                                                                                                                                                                                                                           | [   ] Hours a night                                                                                                                                                                                   |                                                    |
| Living Situation: <input type="checkbox"/> With roommates <input type="checkbox"/> With S/O <input type="checkbox"/> With family <input type="checkbox"/> Other:                                                                                                                                                                |                                                                                                                                                                                                       |                                                    |
| <b>Additional Notes</b><br><br><br><br><br><br><br><br><br><br><p><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></p> <p>Patient name: _____ DOB: _____ Date: _____</p> |                                                                                                                                                                                                       |                                                    |
| <b>Staff Section:</b><br><br><p>Vitals:</p> <p>Height: _____ Weight: _____ BMI: _____</p> <p>BP: _____ HR: _____ Resp: _____ Temp: _____ O2Sat: _____</p> <p>Repeat vitals:</p> <p>Nurses Notes:</p> <p>Providers Notes:</p>                                                                                                    |                                                                                                                                                                                                       |                                                    |

## PERIODIC TUBERCULOSIS (TB) RISK ASSESSMENT TOOL

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

| Periodic Tuberculosis (TB) Risk Assessment Tool                                                                                                                                                                                                                                                                                       |                                                                          | REVIEWER INSTRUCTION                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1. Since your last TB risk assessment, did you have face-to-face contact with someone who was sick with tuberculosis (TB)?<br>If yes, nature of exposure: Household – Co-worker – Family - Other _____<br>Dates of exposure _____                                                                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No                 |                                                                                                |
| 2. Since your last TB risk assessment, did you work, volunteer, or reside in a detainee facility, prison, homeless shelter, refugee camp, or drug treatment facility?                                                                                                                                                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No                 |                                                                                                |
| 3. Since your last TB risk assessment, did you develop any of the following conditions: organ transplant; HIV Infection; Immunosuppression secondary to use of prednisone (equivalent of >15mg/day for >1 month) or other Immunosuppressive medication such as Humira, Enbrel or Remicade?                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No                 |                                                                                                |
| 4. Since your last TB risk assessment, did you develop any of the following conditions: diabetes, silicosis, cancer of head or neck, Hodgkin's disease, leukemia, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight [10% or more below ideal weight], or injection drug use? | <input type="checkbox"/> Yes <input type="checkbox"/> No                 |                                                                                                |
| <b>All "NO" answers = low risk → <u>STOP</u>.</b><br><b>Any "YES" answers = increase risk → <u>Go to question #5</u></b>                                                                                                                                                                                                              |                                                                          | <b>If all "NO" responses → Do NOT test for TB</b>                                              |
| 5. Do you have any of the following symptoms of tuberculosis: cough >2 weeks, fever >2 weeks, drenching night sweats, or unplanned weight loss?                                                                                                                                                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No                 |                                                                                                |
| <b>If "NO" → Go to question #6.</b><br><b>If "YES" → STOP</b>                                                                                                                                                                                                                                                                         |                                                                          | <b>If "YES" then refer immediately to provider for evaluation of TB disease</b>                |
| 6. Have you had a prior TB test, prior diagnosis of TB, or prior treatment for TB?                                                                                                                                                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><u>STOP.</u> |                                                                                                |
| <b>Reviewer comments</b><br><div style="height: 100px; border: 1px solid black;"></div>                                                                                                                                                                                                                                               |                                                                          | <b>If "NO" → Test for TB.</b><br><b>If "YES" → Do NOT test, REFER for provider evaluation.</b> |
| <b>PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last-first-middle; DOB; SSN; date; hospital or medical facility)</b><br><br>NAME:<br>DOB:<br>DoD ID #:<br>DATE:                                                                                                                                                  | <b>REVIEWER NAME</b>                                                     | <b>REVIEWER SIGNATURE</b>                                                                      |
|                                                                                                                                                                                                                                                                                                                                       |                                                                          |                                                                                                |
|                                                                                                                                                                                                                                                                                                                                       |                                                                          |                                                                                                |
|                                                                                                                                                                                                                                                                                                                                       |                                                                          |                                                                                                |

## 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)<br><input type="checkbox"/> BOTH <input type="checkbox"/> INPATIENT <input checked="" type="checkbox"/> OUTPATIENT |                           |

## SECTION II - DISCLOSURE

6. I AUTHORIZE Fox Army Health Center Occupational Health Clinic TO RELEASE MY PATIENT INFORMATION TO:  
(Name of Facility/TRICARE Health Plan)

|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION<br>Hiring civilian Personnel Agency/Human Resources and/or Supervisory Personnel                                                                                                                                                                                                                                                                                                 | b. ADDRESS (Street, City, State and ZIP Code)<br>4100 Goss Road<br>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)<br><input type="checkbox"/> PERSONAL USE <input type="checkbox"/> CONTINUED MEDICAL CARE <input type="checkbox"/> SCHOOL <input checked="" type="checkbox"/> OTHER (Specify) Pre-placement, Fit for duty, Medical qualification or Medical Surveillance exams<br><input type="checkbox"/> INSURANCE <input type="checkbox"/> RETIREMENT/SEPARATION <input type="checkbox"/> 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<br><input type="checkbox"/> DATE (YYYYMMDD) <input type="checkbox"/> 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<br>(If applicable) | 13. DATE (YYYYMMDD) |
|------------------------------------------------------|------------------------------------------------|---------------------|

## SECTION IV - FOR STAFF USE ONLY (To be completed only upon receipt of written revocation)

|                                                                        |                             |                     |
|------------------------------------------------------------------------|-----------------------------|---------------------|
| 14. X IF APPLICABLE:<br><input type="checkbox"/> AUTHORIZATION REVOKED | 15. REVOCATION COMPLETED BY | 16. DATE (YYYYMMDD) |
|------------------------------------------------------------------------|-----------------------------|---------------------|

|                                                                                                                   |                                                                                           |
|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| 17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE<br>Last name, First name:<br>DOB:<br>DoD ID#:<br>Date: | SPONSOR NAME:<br>SPONSOR RANK:<br>FMP/SPONSOR SSN:<br>BRANCH OF SERVICE:<br>PHONE NUMBER: |
|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|

# 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:                                |                     |  |                |                   |                |            |                  |  |  |

**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 \_\_\_\_\_

Job Title \_\_\_\_\_

Age \_\_\_\_\_ Male/ Female  
(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).<br>b. _____ Other type<br><input type="checkbox"/> half- face<br><input type="checkbox"/> full-facepiece type, | <input type="checkbox"/> powered-air purifying,<br><input type="checkbox"/> supplied-air,<br><input type="checkbox"/> 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 <input type="checkbox"/> | No <input type="checkbox"/> |
| Diabetes (sugar disease)                              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Allergic reactions that interfere with your breathing | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Claustrophobia (fear of closed-in places)             | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Trouble smelling odors                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

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

|                                                     |                              |                             |
|-----------------------------------------------------|------------------------------|-----------------------------|
| Asbestosis                                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Asthma                                              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Chronic bronchitis:                                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Emphysema:                                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Pneumonia                                           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Tuberculosis                                        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Silicosis                                           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Pneumothorax (collapsed lung)                       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Lung cancer                                         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Broken ribs:                                        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any chest injuries or surgeries:                    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any other lung problem that you've been told about: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

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

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

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

|                                                        |                              |                             |
|--------------------------------------------------------|------------------------------|-----------------------------|
| Heart attack                                           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Stroke:                                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Angina:                                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart failure:                                         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Swelling in your legs or feet (not caused by walking): | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart arrhythmia (heart beating irregularly):          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| High blood pressure:                                   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any other heart problem that you've been told about:   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

**6. Have you ever had any of the following cardiovascular or heart symptoms?**

|                                                                                    |                              |                             |
|------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| Frequent pain or tightness in your chest                                           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Pain or tightness in your chest during physical activity                           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Pain or tightness in your chest that interferes with your job                      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| In the past two years, have you noticed your heart skipping or missing a beat :    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heartburn or symptoms that is not related to eating                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any other symptoms that you think may be related to heart or circulation problems: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

**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 <input type="checkbox"/>                    | No <input type="checkbox"/> |
| Silica (e.g., in sandblasting)                            | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |
| Tungsten/cobalt (e.g., grinding or welding this material) | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |
| Beryllium:                                                | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |
| Aluminum                                                  | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |
| Coal (for example, mining)                                | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |
| Iron:                                                     | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |
| Tin:                                                      | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |
| Dusty environments:                                       | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |
| Any other hazardous exposures:                            | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |

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<br>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)**

|                                                                                                              |                                                                    |
|--------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> N, R or P disposable respirator (filter-mask, non-cartridge type only)              | <input type="checkbox"/> Supplied air (air line) respirator        |
| <input type="checkbox"/> Negative pressure air-purifying (cartridge) respirator -- either half- or full-face | <input type="checkbox"/> Self-contained breathing apparatus (SCBA) |
| <input type="checkbox"/> 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

☐ Escape only

☐ Moderate exertion

☐ Normal job duties

☐ Heavy exertion

☐ 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: