

Hospitalizations – Please list any **Hospital Admissions**, dates, why you were there:

Social History

	YES	NO	
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	If so, frequency and amount:
Smoke (now or in the past)?	<input type="checkbox"/>	<input type="checkbox"/>	If so, frequency and amount:
Take habit forming drugs?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what are they:
Treated for drug addiction?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when did you complete treatment?
Treated for alcoholism?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when did you complete treatment?

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	16. Do you currently have any work restrictions ? If yes, what are they? _____

Past Occupational History

Please list your **prior jobs** in Reverse Chronology:

Job Title	Employer	Dates of Employment

YES	NO	Don't Know	Immunization (Shots) History
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are your vaccinations up to date?

Respirator Questions:

Check the type of respirator(s) you will use:

- N, R, or P disposable respirator (filter-mask, non- cartridge type only).
- Other type (e.g., half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

YES	NO	Past Respirator Use:
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever worn a respirator? If yes, what type(s): _____

Have you **ever had** any of the following problems with respirator use?

If you have never used a respirator, please check the box & go to the "Spirometry Screening" section below.

<input type="checkbox"/>	<input type="checkbox"/>	Eye irritation?
<input type="checkbox"/>	<input type="checkbox"/>	Skin allergies or rashes?
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety?
<input type="checkbox"/>	<input type="checkbox"/>	General weakness or fatigue?
<input type="checkbox"/>	<input type="checkbox"/>	Any other problem that interferes with your use of a respirator? If yes, please describe problem(s): _____

YES	NO	Spirometry Screening:
<input type="checkbox"/>	<input type="checkbox"/>	Do you currently smoke regularly? - If yes, how many years have you smoked cigarettes? <input type="checkbox"/> < 1 year <input type="checkbox"/> >1 year
<input type="checkbox"/>	<input type="checkbox"/>	<u>Have you smoked within the past hour?</u>
<input type="checkbox"/>	<input type="checkbox"/>	If you do not currently smoke, did you smoke in the past? - If yes, how many years did you smoke cigarettes? <input type="checkbox"/> < 1 year <input type="checkbox"/> >1 year - How many years ago did you quit? <input type="checkbox"/> < 1 year <input type="checkbox"/> >1 year

YES	NO	Spirometry Screening (continued):
		What is the greatest number of packs per day that you have smoked? _____
		- How many packs a day do you smoke now? _____
<input type="checkbox"/>	<input type="checkbox"/>	<u><i>Have you eaten a large meal within the last hour?</i></u>
<input type="checkbox"/>	<input type="checkbox"/>	<u><i>Do you currently have an acute illness?</i></u>
<input type="checkbox"/>	<input type="checkbox"/>	<u><i>In the past 3 weeks, have you had a respiratory illness or ear infection?</i></u>
<input type="checkbox"/>	<input type="checkbox"/>	<u><i>In the past 2 months, have you undergone LASIK eye surgery?</i></u>
<input type="checkbox"/>	<input type="checkbox"/>	<u><i>In the past 3 months, have you undergone any type of surgery other than LASIK?</i></u>
<input type="checkbox"/>	<input type="checkbox"/>	<u><i>In the past 3 months, have you suffered a stroke or heart attack?</i></u>
<input type="checkbox"/>	<input type="checkbox"/>	<u><i>Do you use inhaled medications?</i></u> - If yes, what are their names? _____ - When were they last used? _____
<input type="checkbox"/>	<input type="checkbox"/>	<u><i>Any current history of untreated pneumothorax (collapsed lung)?</i></u>
<input type="checkbox"/>	<input type="checkbox"/>	<u><i>Any unstable heart, vascular conditions?</i></u>
<input type="checkbox"/>	<input type="checkbox"/>	<u><i>Any history of thoracic, abdominal, or cerebral aneurysm?</i></u>
<input type="checkbox"/>	<input type="checkbox"/>	<u><i>Any other current disease that may interfere with test performance?</i></u>

OSHA & General Medical History Questions:

YES	NO	Do you have any of the following symptoms?	Explanation	Current Issue	Past Issue
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath			
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath when walking fast on level ground or walking up a slight hill or incline			
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath when walking with other people at an ordinary pace on level ground			
<input type="checkbox"/>	<input type="checkbox"/>	Have to stop for breath when walking at your own pace on level ground			
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath when washing or dressing yourself			
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath that interferes with your job			
<input type="checkbox"/>	<input type="checkbox"/>	Coughing that produces phlegm (thick sputum)			
<input type="checkbox"/>	<input type="checkbox"/>	Coughing that wakes you early in the morning			
<input type="checkbox"/>	<input type="checkbox"/>	Coughing that occurs mostly when you are lying down			
<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood in the last month			
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing			
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing that interferes with your job			
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain when you breathe deeply			
<input type="checkbox"/>	<input type="checkbox"/>	Any other symptoms that you think may be related to lung problems			
<input type="checkbox"/>	<input type="checkbox"/>	Frequent pain or tightness in your chest			
<input type="checkbox"/>	<input type="checkbox"/>	Pain or tightness in your chest during physical activity			
<input type="checkbox"/>	<input type="checkbox"/>	Pain or tightness in your chest that interferes with your job			
<input type="checkbox"/>	<input type="checkbox"/>	In the past two years, have you noticed your heart skipping or missing a beat			
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn or indigestion NOT related to eating			
<input type="checkbox"/>	<input type="checkbox"/>	Any other symptoms that you think may be related to heart or circulation problems			

YES	NO	General OSHA respirator questions:	Explanation	Current Issue	Past Issue
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever lost vision in either eye (temporarily or permanently)			
<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contact lenses			

YES	NO	General OSHA respirator questions (continued):	Explanation	Current Issue	Past Issue
<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses			
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been or are you currently color blind			
<input type="checkbox"/>	<input type="checkbox"/>	Any other eye or vision problem			
<input type="checkbox"/>	<input type="checkbox"/>	Any ear injuries including a broken ear drum			
<input type="checkbox"/>	<input type="checkbox"/>	Any difficulty hearing			
<input type="checkbox"/>	<input type="checkbox"/>	Do you wear a hearing aid			
<input type="checkbox"/>	<input type="checkbox"/>	Any other hearing or ear problem			
<input type="checkbox"/>	<input type="checkbox"/>	Ever had a back or neck injury			
<input type="checkbox"/>	<input type="checkbox"/>	Any Weakness in any of your arms, hands, legs, or feet			
<input type="checkbox"/>	<input type="checkbox"/>	Back pain			
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty fully moving your arms and legs			
<input type="checkbox"/>	<input type="checkbox"/>	Pain or stiffness when you lean forward or backward at the waist			
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty fully moving your head up or down			
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty fully moving your head side to side			
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty bending at your knees			
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty squatting to the ground			
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs			
<input type="checkbox"/>	<input type="checkbox"/>	Any other muscle or skeletal problem that interferes with using a respirator			

YES	NO	Have you ever had any of the following conditions?	Explanation	Current Issue	Past Issue
<input type="checkbox"/>	<input type="checkbox"/>	Seizures (fits, convulsions) / Epilepsy			
<input type="checkbox"/>	<input type="checkbox"/>	Trouble smelling odors			
<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia (fear of closed-in places)			
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes - If yes, how do you treat it? <input type="checkbox"/> Diet alone <input type="checkbox"/> Diet plus oral medicine <input type="checkbox"/> Diet plus insulin (injection)			
<input type="checkbox"/>	<input type="checkbox"/>	Allergic reactions that interfere with your breathing			
<input type="checkbox"/>	<input type="checkbox"/>	Any allergies in general			
<input type="checkbox"/>	<input type="checkbox"/>	Asthma			
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis: Acute or Chronic			
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia			
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema			
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis			
<input type="checkbox"/>	<input type="checkbox"/>	Asbestosis			
<input type="checkbox"/>	<input type="checkbox"/>	Silicosis			
<input type="checkbox"/>	<input type="checkbox"/>	Pneumothorax (collapsed lung)			
<input type="checkbox"/>	<input type="checkbox"/>	Lung Cancer			
<input type="checkbox"/>	<input type="checkbox"/>	Broken Ribs			
<input type="checkbox"/>	<input type="checkbox"/>	Chest Injuries			
<input type="checkbox"/>	<input type="checkbox"/>	Chest Surgeries			
<input type="checkbox"/>	<input type="checkbox"/>	Any other lung problem that you've been told about			
<input type="checkbox"/>	<input type="checkbox"/>	Stroke			
<input type="checkbox"/>	<input type="checkbox"/>	Numbness / Tingling			

YES	NO	Have you ever had any of the following conditions (continued)?	Explanation	Current Issue	Past Issue
<input type="checkbox"/>	<input type="checkbox"/>	Coma / Loss of Consciousness			
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis			
<input type="checkbox"/>	<input type="checkbox"/>	Vertigo / Fainting / Dizziness			
<input type="checkbox"/>	<input type="checkbox"/>	Nervous / Psychological Condition			
<input type="checkbox"/>	<input type="checkbox"/>	Heart Failure			
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack			
<input type="checkbox"/>	<input type="checkbox"/>	Angina			
<input type="checkbox"/>	<input type="checkbox"/>	Heart Arrhythmia (heart beating irregularly)			
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure			
<input type="checkbox"/>	<input type="checkbox"/>	Any other heart problem that you've been told about			
<input type="checkbox"/>	<input type="checkbox"/>	Swelling in your legs or feet (not caused by walking)			
<input type="checkbox"/>	<input type="checkbox"/>	Skin problems			
<input type="checkbox"/>	<input type="checkbox"/>	LATEX allergy			
<input type="checkbox"/>	<input type="checkbox"/>	Amputations			
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis / Joint problems / injuries			
<input type="checkbox"/>	<input type="checkbox"/>	Broken / Fractured bones			
<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems			
<input type="checkbox"/>	<input type="checkbox"/>	Kidney / Bladder problems			
<input type="checkbox"/>	<input type="checkbox"/>	Hernias			
<input type="checkbox"/>	<input type="checkbox"/>	Other:			

YES	NO	Past	Current	Part B OSHA respirator questions
<input type="checkbox"/>	<input type="checkbox"/>	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 ?		
		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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/>	<input type="checkbox"/>	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?		
		If "yes," name the chemicals if you know them:		
YES	NO	Have you ever worked with any of the materials, or under any of the conditions, listed below? (check "yes" or "no" for all answers that apply to you)?		
<input type="checkbox"/>	<input type="checkbox"/>	Asbestos		
<input type="checkbox"/>	<input type="checkbox"/>	Silica (e.g., in sandblasting)		
<input type="checkbox"/>	<input type="checkbox"/>	Tungsten/cobalt (e.g., grinding or welding this material)		
<input type="checkbox"/>	<input type="checkbox"/>	Beryllium		
<input type="checkbox"/>	<input type="checkbox"/>	Aluminum		
<input type="checkbox"/>	<input type="checkbox"/>	Coal (for example, mining)		
<input type="checkbox"/>	<input type="checkbox"/>	Iron		
<input type="checkbox"/>	<input type="checkbox"/>	Tin		
<input type="checkbox"/>	<input type="checkbox"/>	Dusty environments		
<input type="checkbox"/>	<input type="checkbox"/>	Any other hazardous exposures		
		If "yes," describe these exposures:		

List any second jobs or side businesses you have currently:		
List your current and previous hobbies:		
YES	NO	Part B OSHA respirator questions <i>(continued)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever worked on a HAZMAT team?
<input type="checkbox"/>	<input type="checkbox"/>	Have you been in the military services?
		If "yes," were you exposed to biological or chemical agents (either in training or combat)? <input type="checkbox"/> Yes <input type="checkbox"/> No
YES	NO	Will you be using any of the following items with your respirator(s) (check "yes" or "no" for all answers that apply to you)?
<input type="checkbox"/>	<input type="checkbox"/>	HEPA filters
<input type="checkbox"/>	<input type="checkbox"/>	Canisters (for example, gas masks)
<input type="checkbox"/>	<input type="checkbox"/>	Cartridges
YES	NO	How often are you expected to use the respirator(s) (check "yes" or "no" for all answers that apply to you)?
<input type="checkbox"/>	<input type="checkbox"/>	Escape only (no rescue)
<input type="checkbox"/>	<input type="checkbox"/>	Emergency rescue only
<input type="checkbox"/>	<input type="checkbox"/>	Less than 5 hours <i>per week</i>
<input type="checkbox"/>	<input type="checkbox"/>	Less than 2 hours <i>per day</i>
<input type="checkbox"/>	<input type="checkbox"/>	2 to 4 hours per day
<input type="checkbox"/>	<input type="checkbox"/>	Over 4 hours per day:
YES	NO	During the period you are using the respirator(s), is your work effort :
<input type="checkbox"/>	<input type="checkbox"/>	Light (less than 200 kcal per hour)
		If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.
		Examples of a light work effort are <i>sitting</i> while writing, typing, drafting, or performing light assembly work; or <i>standing</i> while operating a drill press (1-3 lbs.) or controlling machines.
<input type="checkbox"/>	<input type="checkbox"/>	Moderate (200 to 350 kcal per hour)
		If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.
		Examples of moderate work effort are <i>sitting</i> while nailing or filing; <i>driving</i> a truck or bus in urban traffic; <i>standing</i> while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; <i>walking</i> on a level surface about 2 mph or down a 5-degree grade about 3 mph; or <i>pushing</i> a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.
<input type="checkbox"/>	<input type="checkbox"/>	Heavy (above 350 kcal per hour)
		If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.
		Examples of heavy work are <i>lifting</i> a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; <i>shoveling</i> ; <i>standing</i> while bricklaying or chipping castings; <i>walking</i> up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).
<input type="checkbox"/>	<input type="checkbox"/>	Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator?
		If "yes," describe this protective clothing and/or equipment:
<input type="checkbox"/>	<input type="checkbox"/>	Will you be working under hot conditions (temperature exceeding 77 deg. F)
<input type="checkbox"/>	<input type="checkbox"/>	Will you be working under humid conditions

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

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

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):

1. 1st toxic substance name: _____
Estimated maximum exposure level per shift: _____
Duration of exposure per shift: _____
2. 2nd toxic substance name: _____
Estimated maximum exposure level per shift: _____
Duration of exposure per shift: _____
3. 3rd toxic substance name: _____
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:

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):

I certify that the information I have provided on the above medical history pages is complete, true, and accurate to the best of my knowledge. I understand that falsification or omission of any of the preceding information would misinform the medical practitioner of my medical history and potentially result in harm to myself, for which I would not hold the medical practitioner responsible. Additionally, the care and information you received today is not a substitute for the care and information that you receive from your primary care physician. I agree that the Health Examination requested by my company is made with my consent and that the examination, test(s), and/or result(s) may be released to the above-named company and/or its representatives.

Patient Signature

Printed

Date/Time

Reviewer's Signature

Printed

Date/Time