

SAMPLE RESPIRATORY MEDICAL CLEARANCE QUESTIONNAIRE

Dear Firefighter:

This is a reminder that this respiratory medical clearance questionnaire is part of a safety process adopted for the protection of each firefighter, their co-workers and the public. It must be completed annually and responses must be complete. Firefighters are expected to fill out this form truthfully in accordance with the Fire Department policy. This document is not valid unless signed and dated.

First Name <small>(Please Print)</small>	Last Name	Job Title
I/I #	Company	Shift
Signature <small>(form must be signed and dated to be valid)</small>	Date	

Part 1 – Employee Background Information – ALL employees must complete this section (Please Print)

Age (to nearest year)	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Height (Feet & Inches)	Weight (pounds)
1.	2.	3.	4.

Phone number(s) where you can be reached by the health care provider who reviews this form.

Best time to contact you at the number(s) listed

Has your employer told you how to contact the health care provider who reviews this questionnaire? Yes
No

Check the type of respirators that you will be using:

- | | | |
|--|--|---|
| <input type="checkbox"/> SCBA: Pressure Demand | <input type="checkbox"/> SCBA Rebreather | <input type="checkbox"/> SCBA |
| <input type="checkbox"/> WMD Escape Hood | <input type="checkbox"/> Supplied Air FF Respirator | <input type="checkbox"/> Emerg. Escape Breathing System |
| Negative Pressure APR: <input type="checkbox"/> Half Mask <input type="checkbox"/> Full Mask | <input type="checkbox"/> Powered Air Purifying Resp (PAPR) | |
| <input type="checkbox"/> Filtering Facepiece, N95 or N100 (HEPA) Mask | <input type="checkbox"/> Other _____ | |

You may be contacted if there are questions about your responses to this questionnaire, or there is a need for further clinical information relative to respiratory medical clearance only.

Please note for any question below, any medical issues that occurred prior to age 16 and healed without any residual problems you may check “no” on the questionnaire. This avoids unnecessary follow up calls, for example, if you had a childhood ear infections, broken ribs playing soccer, etc.

Without complete information, respiratory medical clearance may be delayed or may not be issued.

Part 2-General Health Information**ALL employees must complete this part - Please check "Yes" or "No"**Yes 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?Yes No

a. Seizures (fits)

Yes No

b. Diabetes (sugar disease)

Yes No

c. Allergic reactions that interfere with your breathing d.

Yes No

Claustrophobia (fear of closed-in places)

Yes No

e. Trouble smelling odors

Yes No 3. Have you **ever had** any of the following pulmonary or lung problems?Yes No

a. Asbestosis

Yes No

b. Asthma

Yes No **-If you checked yes,****I. Are you under a doctor's care?**Yes No **II. Do you take medications for this problem?**Yes No **III. Have you had worsening of the problem in the last year requiring an urgent appointment, hospital admission or emergency room evaluation?**Yes No

c. Chronic bronchitis

Yes No **-If you checked yes,****I. Are you under a doctor's care?**Yes No **II. Do you take medications for this problem?**Yes No **III. Have you had worsening of the problem in the last year requiring an urgent appointment, hospital admission or emergency room evaluation?**Yes No

d. Emphysema

Yes No **-If you checked yes,****I. Are you under a doctor's care?**Yes No **II. Do you take medications for this problem?**Yes No **III. Have you had worsening of the problem in the last year requiring an urgent appointment, hospital admission or emergency room evaluation?**Yes No

e. Pneumonia

Yes No **-If you checked yes, have you completed treatment?**Yes No

f. Tuberculosis

Yes No

g. Silicosis

Yes No

h. Pneumothorax (collapsed lung)

Yes No

i. Lung cancer

Yes No

j. Broken ribs

Yes No **-If you checked yes, do you have any residual pain or symptoms?**Yes No

k. Any chest injuries or surgeries:

Yes No **-If you checked yes, do you have any residual pain or symptoms?**Yes No

l. Any other lung problem that you have been told about

Yes No Yes No 4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?Yes No

a. Shortness of breath

Yes No

b. Shortness of breath walking fast on level ground or walking up a slight hill or incline c.

Shortness of breath walking with other people at an ordinary pace on level ground

Yes No

d. Have to stop for breath when walking at your own pace on level ground e.

Yes No

Shortness of breath when bathing or dressing yourself

Yes No

f. Shortness of breath that interferes with your job

Yes No

g. Coughing that produces phlegm (thick sputum)

- Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
- h. Coughing that wakes you early in the morning
 - i. Coughing that occurs mostly when you are lying down j. Coughing up blood in the last month
 - k. Wheezing
 - l. Wheezing that interferes with your job
 - m. Chest pain when you breathe deeply
 - n. Any other symptoms that you think may be related to lung problems

5. Have you **ever had** any of the following cardiovascular or heart problems?
- Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
- a. Heart attack
 - b. Stroke
 - c. Angina
 - d. Heart failure
 - e. Swelling in your legs or feet (not caused by walking)
 - f. Heart arrhythmia (heart beating irregularly)
 - g. High blood pressure *-If you checked yes,*
 - I. Are you under a doctor's care?
 - II. Do you take medications for this problem?
 - III. Have you had worsening of the problem in the last year requiring an urgent appointment, hospital admission or emergency room evaluation?
 - IV. Is your blood pressure under 140/90?
 - h. Any other heart problem that you have been told about?
-If you checked yes, please list the name on the left.

6. Have you **ever had** any of the following cardiovascular or heart symptoms?
- Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
 - Yes No
- a. Frequent pain or tightness in your chest
 - b. Pain or tightness in your chest during physical activity
 - c. Pain or tightness in your chest that interferes with your job
 - d. In the past two years, have you noticed your heart skipping or missing a beat?
-If you checked yes,
 - I. Are you under a doctor's care?
 - II. Do you take medications for this problem?
 - III. Have you had worsening of the problem in the last year requiring an urgent appointment, hospital admission or emergency room evaluation?
 - IV. Has this been diagnosed as PVCs or PACs?
 - e. Heartburn or indigestion that isn't related to eating
 - f. Any other symptoms that you think may be related to heart or circulation problems

7. Do you **currently** take medication for any of the following problems?
- Yes No
 - Yes No
 - Yes No
 - Yes No
- a. Breathing or lung problems
 - b. Heart trouble
 - c. Blood pressure
 - d. Seizures (fits)

8. If you have used a respirator, have you **ever had** any of the following problems?
(If you have never used a respirator, write N/A in the column to the left and go to question 9.)

Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No

- a. Eye irritation **-If you checked yes,**
I. Was this a limited event that resolved within a day?
II. Did it interfere with your ability to continue to use the respiratory equipment at the time?
- b. Skin allergies or rashes **-If you checked yes**
I. Was this a limited event that resolved within a day?
II. Did it interfere with your ability to continue to use the respiratory equipment at the time?
- c. Anxiety:
- d. General weakness or fatigue
- e. 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?

Part 3-Additional Questions for Users of Full-Facepiece Respirators or SCBAs

Please check "Yes" or "No"

Yes No

1. Have you **ever lost** vision in either eye (temporarily or permanently)?

Yes No Yes No Yes No Yes No

2. Do you **currently** have any of these vision problems?

- a. Need to wear contact lenses
 b. Need to wear glasses
 c. Color blindness
 d. Any other eye or vision problem

Yes No

3. Have you **ever had** an injury to your ears, including a broken ear drum?

-If you checked yes,

Yes No

I. Is the injury healed?

Yes No

II. Do you have ongoing drainage from the ear?

Yes No

III. Does it still hurt?

Yes No

4. Do you **currently** have any of these hearing problems?

- a. Difficulty hearing
 b. Need to wear a hearing aid
 c. Any other hearing or ear problem

Yes No Yes No Yes No Yes No

5. Have you **ever had** a back injury?

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

- Yes No a. Back pain
- Yes No b. Difficulty fully moving your arms and legs
- Yes No c. Pain or stiffness when you lean forward or backward at the waist
- Yes No d. Difficulty fully moving your head up or down
- Yes No e. Difficulty fully moving your head side to side
- Yes No f. Difficulty bending at your knees
- Yes No g. Difficulty squatting to the ground
- Yes No h. Climbing a flight of stairs or a ladder carrying more than 25 lbs
- Yes No i. Any other muscle or skeletal problem not previously mentioned

If you responded yes to ANY of the above, do these symptoms impair your ability to put on, carry, use or remove the SCBA and other respiratory protection equipment?

Yes No 7. Do you now, or have you **ever had** weakness in any of your arms, hands, legs, or feet?

Part 4: Please list all medications that you are currently taking:

Name of Medication	Dose (e.g. 250 mg.)	Frequency (e.g. once daily)