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.

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First Name **(Please Print)** _____ Last Name _____ Job Title _____

I/I # _____ Company _____ Shift _____

Signature _____ Date _____
(form must be signed and dated to be valid)

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

Age (to nearest year)	Male ❑ Female❑ Sex	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:

❑ SCBA: Pressure Demand ❑ SCBA Rebreather ❑ SCBA

❑ WMD Escape Hood ❑ Supplied Air FF Respirator ❑ Emerg. Escape Breathing System

Negative Pressure APR: ❑ Half Mask ❑ Full Mask ❑ Powered Air Purifying Resp (PAPR)

❑ Filtering Facepiece, N95 or N100 (HEPA) Mask ❑ 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?

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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

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

Yes ❑ No ❑ a. Asbestosis
Yes ❑ No ❑ b. Asthma
-If you checked yes,
Yes ❑ No ❑ **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
-If you checked yes,
Yes ❑ No ❑ **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
-If you checked yes,
Yes ❑ No❑ **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
-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
-If you checked yes, do you have any residual pain or symptoms?
Yes ❑ No ❑ k. Any chest injuries or surgeries:
-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

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

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

Yes ❑ No ❑ a. Heart attack
Yes ❑ No ❑ b. Stroke
Yes ❑ No ❑ c. Angina
Yes ❑ No ❑ d. Heart failure
Yes ❑ No ❑ e. Swelling in your legs or feet (not caused by walking)
Yes ❑ No ❑ f. Heart arrhythmia (heart beating irregularly)
Yes ❑ No ❑ 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?
Yes ❑ No ❑ h. Any other heart problem that you have been told about?
-If you checked yes, please list the name on the left.

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

Yes ❑ No ❑ a. Frequent pain or tightness in your chest
Yes ❑ No ❑ b. Pain or tightness in your chest during physical activity
Yes ❑ No ❑ c. Pain or tightness in your chest that interferes with your job
Yes ❑ No ❑ 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?
Yes ❑ No ❑ e. Heartburn or indigestion that isn't related to eating
Yes ❑ No ❑ f. Any other symptoms that you think may be related to heart or circulation problems

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7. Do you **currently** take medication for any of the following problems?

Yes ❑ No ❑ a. Breathing or lung problems
Yes ❑ No ❑ b. Heart trouble
Yes ❑ No ❑ c. Blood pressure
Yes ❑ No ❑ d. Seizures (fits)

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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 ❑ a. Eye irritation ***-If you checked yes,***
Yes ❑ No ❑ **I.** Was this a limited event that resolved within a day?
Yes ❑ No ❑ **II.** Did it interfere with your ability to continue to use the respiratory equipment at the time?

Yes ❑ No ❑ b. Skin allergies or rashes ***-If you checked yes***
Yes ❑ No ❑ **I.** Was this a limited event that resolved within a day?
Yes ❑ No ❑ **II.** Did it interfere with your ability to continue to use the respiratory equipment at the time?

Yes ❑ No ❑ c. Anxiety:

Yes ❑ No ❑ d. General weakness or fatigue
Yes ❑ No ❑ 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)?

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

Yes ❑ No ❑ a. Need to wear contact lenses
Yes ❑ No ❑ b. Need to wear glasses
Yes ❑ No ❑ c. Color blindness
Yes ❑ No ❑ 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?

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

Yes ❑ No ❑ a. Difficulty hearing
Yes ❑ No ❑ b. Need to wear a hearing aid
Yes ❑ No ❑ c. Any other hearing or ear problem

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 d.
Yes ❑ No ❑ Difficulty fully moving your head up or down
Yes ❑ No ❑ e. Difficulty fully moving your head side to side f.
Yes ❑ No ❑ 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

Yes ❑ No ❑ **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)