CARROLL OCCUPATIONAL HEALTH
Affiliated with Carroll Hospital Center

Frederick Health
Employer Solutions

Date: _____

Dear:

Your Fire Department physical is scheduled for:____/_____/_____@_____

Prior to your physical you will need to:

- Complete all enclosed forms.
- Have your Chief or authorized personnel complete your authorization form.
- If under 18, have your parent or guardian sign your parental consent form.

For **the day of** your physical you will need to:

- **Fast** at least 8 hours for your blood work. Water is allowed, and take any scheduled medications.
- **Complete Hemacult** and bring with you, instruction sheet is in the packet.
- Make sure you are **clean shaven** for your Fit Test. Bring personal mask if you have one.
- Wear **comfortable clothes and shoes for Stress Test** if applicable.
- **Females**-you will need a copy of your most recent well woman check-up and mammogram.

All pending information must be provided to Carroll Occupational Health or Frederick Health Employer Solutions within 2 weeks of the date of your physical or you will not be qualified.

Please do not hesitate to contact me with any questions. We look forward to your visit and appreciate your dedication to our community.

Sincerely,

Lisa Degitz
Practice Manager

CARROLL OCCUPATIONAL HEALTH
Affiliated with Carroll Hospital Center

Frederick Health
Employer Solutions

AUTHORIZATION FOR MEDICAL SERVICES MUST BE PRESENTED AT TIME OF SERVICE

COMPANY NAME	**CC Volunteer Emer. Svc. Assoc**	
NAME OF STATION	**EMPLOYEE'S NAME**	
I authorize to you to provide this employee with the medical attention indicated below. I further acknowledge my company's responsibility for the payment of services.		
AUTHORIZED BY *(SIGNATURE)*	**DATE SIGNED**	**PRINTED NAME**
TITLE	**PHONE NO.**	

_____ Work-Related Injury Date of Injury: _____ ☐ Paid ☐ Volunteer

What Station was employee working/volunteering at when Injury occurred?

_____

☐ ATR ☐ HazMat ☐ Fire Police ☐ Dive Team ☐ Driver	**☐ Approved for Saturday Appt.**

PHYSICAL EXAMS

Check examination requested.

_____ **Initial Emergency Responder Physical**

_____ **Annual Emergency Responder Physical**

_____ **Fitness-For-Duty**

_____ **Return-to-Work Urine Drug Screen 5 Panel Non-DOT**

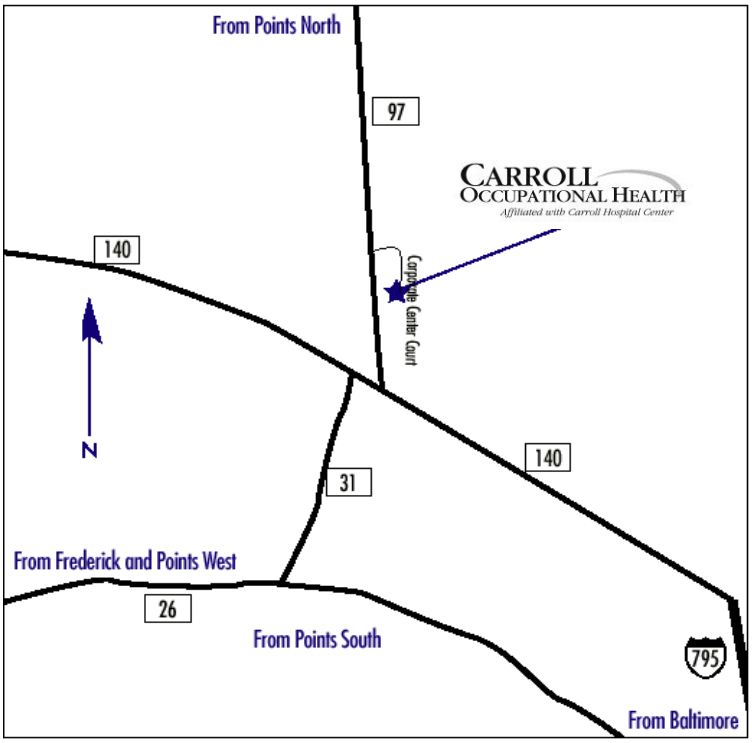
_____ **Requires DOT Physical**

Carroll Occupational Health
700-B Corporate Center Court, Suite A
Westminster, MD 21157
Appointments: 410-871-0470
Fax: 410-871-0743

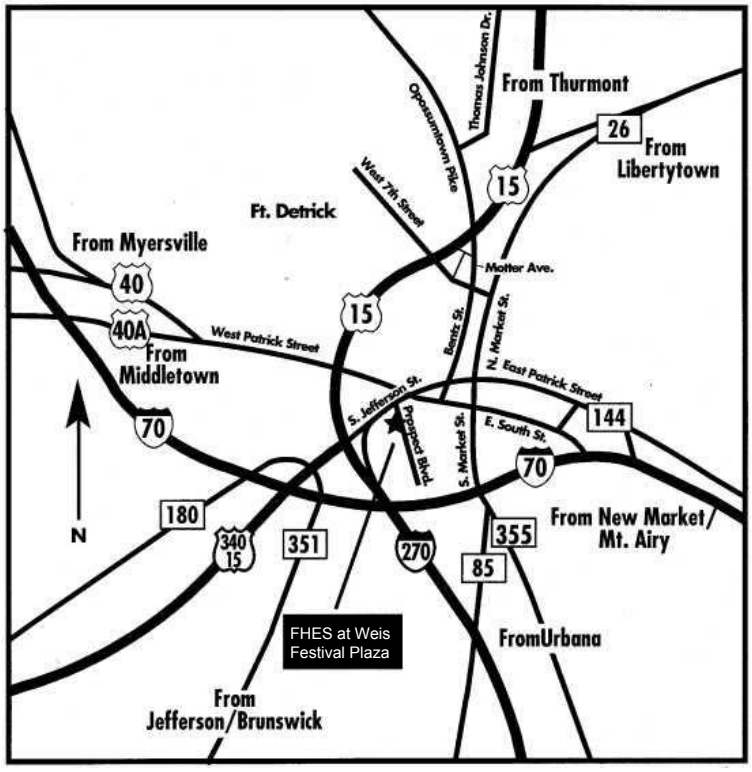
Frederick Health Employer Solutions
490-L Prospect Blvd
Fredeick, MD 21701
Appointments: 240-566-3001
Fax: 240-566-3003

Hours: Monday – Friday – 7:00am – 5:00pm

Carroll Occupational Health:



Frederick Health Employer Solutions:



Patient Name: _____ Company: _____ Date: _____

Company Contact: _____

Birthdate: ___/___/___ Age ____

Medical History - Comprehensive

Allergies: Latex: _____ Yes _____ No
Medication Allergies: _____
Other Allergies:_____

Last Tetanus booster: _____
Current Medications: _____
_____
Current Physician: _____

Medical Illnesses - check all that apply:

___ High Blood Pressure
___ Lung Disease
___ Diabetes
___ Seizures
___ Heart Disease
___ Kidney Disease
___ Anemia
___ Cancer
___ Stomach or Bowel Disorders: _____
___ Sleep Apnea
___ Fractures & Joint Injuries: _____
___ Other: _____
Surgeries: _____

Social History - Check all that apply :

___ Tobacco use
___ Cigarettes: ___ packs/day ___ years
___ Cigars: ___ per day ___ years
___ Pipe: ___ years
___ Chew/Snuff: ___ years

___ Alcohol use ___ Drinks per week

Place an X in the box if you have any of the conditions below now or in the past:
(Caregivers: please comment on positive responses):

Vision (Vision)

__ 1. Do you use glasses?:
__ For reading
__ For distant vision
__ Contacts
__ 2. Are you color blind?

3. Do you have:
__ Retinal disease
__ Cataracts
__ Glaucoma
__ 4. Do you use eye medicine?
__ 5. Have you had eye surgery?
__ 6. Have you had laser exposure?

Heart/Vascular

Do you have:
__16. Chest pain on effort
__17. High blood pressure
__18. Shortness of breath
__19. Swelling of ankles
__20. Heart murmur

Have you had:
__21. Heart attack
__22. Stroke
__23. Rheumatic fever
__24. Heart failure
__25. Heart surgery/Stent/Pacemaker

Hearing
Do you have
__ 7. Difficulty hearing
__ 8. Ear disease
__ 9. Ringing in the ears
__10. Abnormal hearing test
__11. Do you use a hearing aid?
__12. Have you had ear surgery?
__13. Ruptured ear drum?
__14. Exposure to gunfire?
__15. Wear hearing protection?

Liver or Gastrointestinal
Do you have or have you had:

__37. Hepatitis
__38. Cirrhosis
__39. Jaundice
__40. Frequent indigestion
__41. Ulcer disease
__42. Colitis
__43. Other intestinal problems
__44. Do you have a hernia?
__45. Have you had hernia surgery?

Genitourinary:
Do you or have you had:

__46. Kidney trouble
__47. Bladder trouble
__48. Kidney stones

Skin:

__49. Do you have eczema?
__50. Do you have psoriasis?
__51. Any other skin conditions

Neurologic

__52. Tremors
__53. Dizzy spells
__54. Convulsions
__56. Nerve damage
__57. Serious head injury
__58. Brain surgery
__59. Nervous breakdown

Are you taking medication for:

__60. Anxiety or depression
__61. Epilepsy
__62. Parkinson's disease

Respiratory
Do you have:
__26. Chronic cough
__27. Asthma
__28. Bronchitis
__29. Hay fever
__30. Emphysema/COPD
Have you had:
__31. Tuberculosis
__32. Lung cancer
__33. Lung surgery
__34. Silicosis
__35. Asbestos
__36. Black lung

Blood, Endocrine
Have you had:

__63. Anemia
__64. Bleeding problems
__65. Hormone problems
__66. Diabetes
__67. Thyroid problem

Musculoskeletal:
Do you or have you had:

__68. Back trouble
__69. Disc problems/surgery
__70. Shoulder problems/surgery
__71. Arm problems/surgery
__72. Wrist problems/surgery
__73. Hand problems/surgery
__74. Hip problems/surgery
__75. Leg problems/surgery
__76. Knee problems/surgery
__77. Ankle problems/surgery
__78. Foot problems/surgery
__79. Broken bones
__80. Numbness, tingling, and/or pain in hands or arms

Communicable Diseases:
Have you had:

__81. Chicken pox
__82. Measles
__83. German Measles
__84. Mumps
__85. Hepatitis A
__86. Hepatitis B
__87. Hepatitis C

Please list all prior jobs:

Company Name:	Dates Employed:	Job Description:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle any of the following processes and/or jobs done in the past:

Processes: abrasive blasting, acid/alkali treatment, degreasing, electroplating, foundry, forging, painting, welding, grinding or metal machining

Industries: flour,feed or grain, cotton processing, rubber, insulation, quarry work, construction, farming, petroleum, shipyards

Circle any of the following substances to which you have had regular exposure in the workplace:

Fumes or dusts:
silica, coal, asbestos, talc, fiberglass, cotton dust, sawdust
other: _____

Solvents:
benzene, carbon tetrachloride, trichloroethylene, naptha, xylene
other : _____

Chemicals or gases :
ammonia, formaldehyde, hydrogen sulfide, cyanide, sulfur dioxide, chromium, mercury, lead, cadmium, nickel
other: _____

Miscellaneous:
radiation, insecticides/herbicides, cutting oils, motor exhaust, noise

Have you ever needed medical care for exposure to any of the above?
___ Yes ___ No

Type of problem: Skin: _____ Lungs: _____ Other: _____

Work related injuries and illnesses:

Year:	Injury and treatment:	Time off work:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes	No	Explain if yes
___	___	Have you ever applied for worker's compensation or disability payments for any injury or illness which developed on the job? Explain: _____

___ ___ Are you currently being treated by a doctor for a work related injury or illness? Explain:

_____

_____ _____

Employee Signature Date

_____ _____

Reviewed By Date

f-hxcomp

Patient Name: _____ Company: _____ Date: _____

Company Contact: _____

Birthdate: ___/___/___ Age ____

AUDIO HISTORY FORM

Department: _____ Shift: _____ Job Title: _____
Sex: _____ Male _____ Female

Type of Test: (Circle One) PREPLACEMENT BASELINE (Initial) ANNUAL
RETEST TERMINATION OTHER

Have you been exposed to noise within the last 14 hours? [ ] Yes [ ] No
Explain: _____

How do you rate your hearing?
[ ] Unknown [ ] Very poor [ ] Average [ ] Good [ ] Very good

Hearing protection, Do you wear while at work?

[ ] Not used [ ] Seldom used [ ] Sometime used
[ ] ½ time [ ] Usually used [ ] Always used
If yes, what type of hearing protection do you wear?

[ ] Earplugs [ ] Earmuffs [ ] Both Brand: _____

MEDICAL HISTORY: (Check the correct answer)

10. Ear pain	[ ] Yes [ ] No	25. Scarlet Fever	[ ] Yes [ ] No
11. Draining Ear	[ ] Yes [ ] No	26. Measles	[ ] Yes [ ] No
12. Dizziness/imbalance	[ ] Yes [ ] No	27. Meningitis	[ ] Yes [ ] No
13. Severe ringing	[ ] Yes [ ] No	28. Diabetes	[ ] Yes [ ] No
14. Sudden hearing loss	[ ] Yes [ ] No	29. Kidney disease	[ ] Yes [ ] No
15. Fluctuating hearing loss	[ ] Yes [ ] No	30. Visible wax/objects	[ ] Yes [ ] No
16. Fullness/discomfort	[ ] Yes [ ] No	31. Allergies	[ ] Yes [ ] No
17. History of prior Disease/ear problem	[ ] Yes [ ] No	32. Family hearing loss	[ ] Yes [ ] No
18. Recent prescription Drugs	[ ] Yes [ ] No	33. High noise exposure today	[ ] Yes [ ] No
19. High blood pressure	[ ] Yes [ ] No	34. History of prior ear disease before test	[ ] Yes [ ] No
20. See MD for ears	[ ] Yes [ ] No	35. Head cold today	[ ] Yes [ ] No
21. Ear surgery	[ ] Yes [ ] No	36. Military service	[ ] Yes [ ] No
22. Unconsciousness	[ ] Yes [ ] No	37. Noisy hobbies	[ ] Yes [ ] No
23. Wear hearing aid	[ ] Yes [ ] No	38. Loud music/ headphones	[ ] Yes [ ] No
24. Mumps	[ ] Yes [ ] No	39. Firearms/guns	[ ] Yes [ ] No

Explain any "yes" answers: _____
_____

MEDICATIONS (Past and Present) (Please check appropriate boxes)
[ ] Aspirin, Buffered, Exedrin (more than 6/day)
[ ] Neomycin [ ] Streptomnycin [ ] Gentamycin [ ] Quinine
Explain any checked answers: _____
_____

_____
Signature Date

OTOSCOPIC EXAM:
Right [ ] Normal [ ] Abnormal _____ Examiners Initials _____
Left [ ] Normal [ ] Abnormal _____ Examiners Initials _____

Patient Name: _____ Company: _____ Date: _____

Company Contact: _____

Birthdate: ___/___/___ Age ____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

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

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

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

Patient Signature: _____

Caregiver Signature: _____

f-epwort

OSHA Mandatory Respirator Medical Evaluation Questionnaire
29 CFR 1910.134

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: □ yes □ no

Your employer must allow you to answer the questionnaire during normal working hours, or at a time 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

1. Today's Date ____/____/____	2. Your Name	3.Your Age
4. Leave Blank	5. Your Job Title	6. Your Date of Birth
7. Sex (circle one) Male Female	8. Your Height _____Ft. _____in.	9. Your Weight _____Lbs.

10. Phone # where you can be reached to discuss your answers: (_____) _____-_____	11. The best time to call you at this number: _____ a.m. p.m.

12. Has your employer told you how to contact the health care professional who will review this questionnaire? □ yes □ no

13. Check the type of respirator you will use. (You can check more than one category)
    a. □ N,R, or P disposable respirator (filter-mask, non-cartridge type only).
    b. □ Other type (for example, half- or full-facepiece type, powered-air purifying supplied air, self-contained breathing apparatus).

14. Have you worn a respirator? □ 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.

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?

a. Seizures (fits) □ yes □ no	b. Diabetes (sugar disease): □ yes □ no	c. Trouble smelling odors: □ yes □ no
d. Claustrophobia (fear of closed-in places) □ yes □ no	e. Allergic reaction that interfere with your breathing? □ yes □ no	

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

a. Asbestosis □ yes □ no	b. Asthma □ yes □ no	c. Chronic bronchitis □ yes □ no
d. Emphysema □ yes □ no	e. Pneumonia □ 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	k. Any chest injuries or surgeries □ yes □ no	l. Any other lung problem you've been told about □ yes □ no

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

a. Shortness of breath: □ yes □ no

b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: □ yes □ no

c. Shortness of breath when 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: □ yes □ no

e. Shortness of breath when washing 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: □ yes □ no

j. 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: □ yes □ no

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

a. Heart attack □ yes □ no	b. Stroke: □ yes □ no
c. Angina □ yes □ no	d. Swelling in your legs and feet (not caused by walking) □ yes □ no
e. Heart Failure □ yes □ no	f. Heart arrhythmia (irregular heart beat) □ yes □ no
g. High blood pressure □ yes □ no	h. Any other heart problem that you've been told about: □ yes □ no

6. Have you *ever had* any of the following cardiovascular or heart symptoms?
   a. Frequent pain or tightness in the 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: □ yes □ no

   e. Heartburn or indigestion that is not related to eating: □ yes □ no

   f. Any symptoms that you think may be related to heart or circulation problems: □ yes □ no

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

Breathing problems	Heart trouble	Blood Pressure	Seizures (fits)
□ yes □ no	□ yes □ no	□ yes □ no	□ 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 box and go to question 9. □

a. Eye Irritation: □ yes □ no	b. Skin allergies or rashes: □ 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 to this questionnaire: □ yes □ no

Questions 10 to 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:

a. Wear contact lenses: □ yes □ no	b. Wear glasses: □ yes □ no
c. Color blind: □ yes □ no	d. Any other eye or vision problem: □ yes □ no

12. Have you *ever had* an injury to you ears, including a broken eardrum: □ yes □ no

13. Do you *currently* have any of the following hearing problems?
   a. Difficulty hearing: □ yes □ no
   b. Wear a hearing aid: □ yes □ no
   c. 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?

a. Weakness in any of your arms, hands, legs or feet: □ yes □ no	b. Back pain □ yes □ no
c. Difficulty fully moving you arms & legs: □ yes □ no	d. Pain or stiffness when you lean forward or backward at the waist: □ yes □ no
e. Difficulty fully moving your head up or down: □ yes □ no	f. Difficulty fully moving your head side to side: □ yes □ no
g. Difficulty bending at your knees: □ yes □ no	h. Difficulty squatting to the ground: □ yes □ no
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.: □ yes □ no	j. 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 ft) 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:
   _____
   _____

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

a. Asbestos: □ yes □ no	b. Silica: □ yes □ no	c. Tungsten/Cobalt: □ yes □ no
d. Beryllium: □ yes □ no	e. Aluminum □ yes :□ no	f. Coal: □ yes □ no
g. Iron: □ yes □ no	h. Tin: □ yes □ no	i. Dusty environments: □ yes □ no

j. Any other hazardous exposures: □ yes □ no
If "yes" describe the exposure:

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

5. List your previous occupations:

6. List your current & previous hobbies:

7. Have you been in the military service? ☐ yes ☐ no

If "yes" describe these exposures:

8. Have you ever worked on a HAZMAT team? ☐ yes ☐ no

9. Other than the 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)?

a. HEPA Filters ☐ yes ☐ no	b. Canisters (e.g. gas masks) ☐ yes ☐ no	c. Cartridges ☐ yes ☐ no

11. How often are you expected to use the respirator:

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:

a. *Light* (less than 200 kcal per hour): ☐ yes ☐ no

If "yes", how long does this period last during the average shift

_____ hours _____minutes

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.

b. *Moderate* (200 to 350 kcal per hour) ☐ yes ☐ no

If "yes", how long does this period last during the average shift

_____ hours _____minutes

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.

c. Heavy (above 350 kcal per hour): □ yes □ no

If "yes", how long does this period last during the average shift

_____ hours _____minutes

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 the respirator:

□ yes □ no

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

14 Will you be working under hot conditions (temperature exceeding 77 degrees 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) (e.g., 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 - #1
Estimated maximum exposure level per shift
Duration of exposure per shift:

Name of toxic substance - #2
Estimated maximum exposure level per shift
Duration of exposure per shift

Name of toxic substance - #3
Estimated maximum exposure level per shift

Duration of exposure per shift

Name of toxic substance - #4
Estimated maximum exposure level per shift
Duration of exposure per shift

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

_____ _____

Employee Signature **Date**

OSHA Mandatory Respirator Medical Evaluation Questionnaire Reviewed by:

_____ _____

Healthcare Provider Signature **Date**