

Lisbon Physical Protocol

Prior to your physical you will need to:

- Complete all attached forms.
- Have your Chief or authorized personnel complete your authorization form.
- If you are under 18, have your parent or guardian sign the parental consent form.
- If you have immunization records, please bring them with you.
- Physicals average 2-2 1/2 hours so please allow time to complete all components

For the day of your physical you will need to:

- **Fast** at least 8 hours for your blood work. Water is allowed. Take any scheduled medications.
- Males 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**

PPD Testing:

- 2 visit tests- administered one day and read 48-72 hours after placement. You may also come to the office, up to 72 hours prior to your scheduled physical to have your ppd placed so it can be read the day of your physical.

Your test must be read by staff at Carroll Occupational Health or Frederick Health Employer Solutions

NO OUTSIDE INTERPRETATIONS WILL BE ACCEPTED

**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 the community.

Carroll Occupational Health - 410-871-0470

Frederick Health Employer Solutions – 240-566-3001

Procedures for Lisbon Physical Program

- Audio
- BMI/Body Fat
- Chest X-ray (every 5 years)
- DOT Physicals (as requested)
- Drug Screen
- Enhanced Health Profile (Comprehensive Metabolic Panel, CBC w/diff, Urinalysis and Coronary Risk Profile)
- Hepatitis B Titer and/or Hepatitis B Series (Initial and Post Exposure)
- Hepatitis C Antibody (Initial and Post Exposure)
- MMR Titer (Initial)
- Varicella Titer and/or Varicella Vaccination
- Pulmonary Function Test
- Physical
- PPD Testing (Tuberculosis) (Initial and Annual)
- Quantitative Fit Tests(SCBA and N95)
- Stress Test
- Tetanus (every 10 years)
- Titmus (Vision)
- PSA (male 39+)

***Personnel who have had a recent positive stress test will bring results to appointment and may not be required to complete the stress testing portion of the physical**

***Please provide any immunization records available.**

Parental Permission Form

I/We _____, parent/guardian of _____,
a minor child, understand that in accordance with the Health and Wellness Physical standards of the Carroll County
Volunteer Fireman's Association, certain medical testing is required. I/We as parent/guardian of
_____ grant permission for the following testing and treatment concerning the minor
child:

Fire Department Physical	Yes	No
Blood Draw Analysis	Yes	No
Urine Analysis	Yes	No
Immunizations as needed	Yes	No

I/We further consent to the disclosure to the Carroll County Volunteer Fireman's Association of any doctor's
opinions concerning fitness and testing results concerning the testing and treatment consented to above. This
authorization for the disclosure of medical information is valid for a period of six months from the date of execution
of this document.

Parent/Guardian _____
Print

Sign

Mailing Address _____

Telephone Number _____

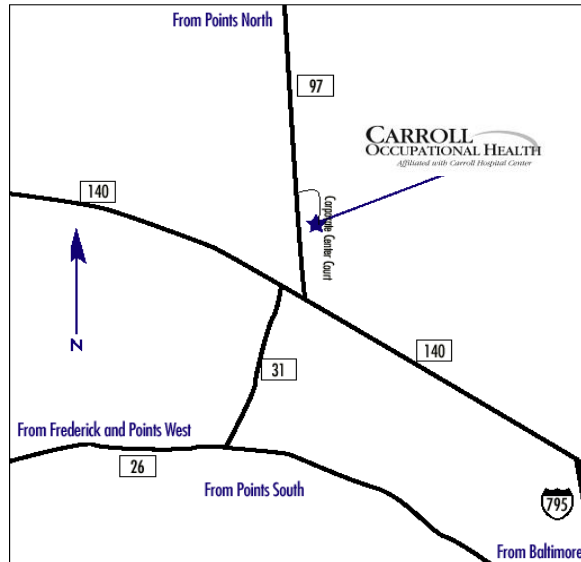
Emergency Contact Number _____

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

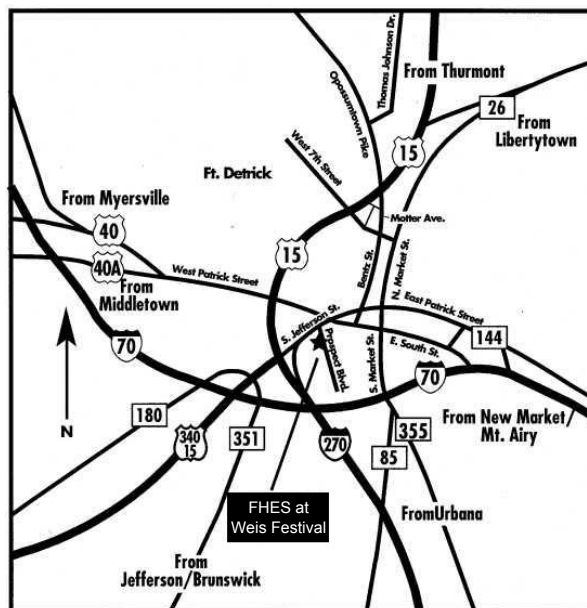
Frederick Health Employer Solutions
490-L Prospect Blvd
Frederick, MD 21701
Appointments: 240-566-3001
Fax: 240-566-3003

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:

- | | |
|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stomach or Bowel Disorders: _____ | |
| <input type="checkbox"/> Sleep Apnea | |
| <input type="checkbox"/> Fractures & Joint Injuries: _____ | |
| <input type="checkbox"/> Other: _____ | |
| Surgeries: _____ | |

Social History - Check all that apply :

- | | | |
|--------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Tobacco use | <input type="checkbox"/> Cigarettes: _____ packs/day | <input type="checkbox"/> _____ years |
| | <input type="checkbox"/> Cigars: _____ per day | <input type="checkbox"/> _____ years |
| | <input type="checkbox"/> Pipe: _____ years | |
| | <input type="checkbox"/> Chew/Snuff: _____ years | |
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> 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)

- | | |
|--|--|
| <input type="checkbox"/> 1. Do you use glasses?: | Heart/Vascular |
| | Do you have: |
| <input type="checkbox"/> For reading | <input type="checkbox"/> 16. Chest pain on effort |
| <input type="checkbox"/> For distant vision | <input type="checkbox"/> 17. High blood pressure |
| <input type="checkbox"/> Contacts | <input type="checkbox"/> 18. Shortness of breath |
| <input type="checkbox"/> 2. Are you color blind? | <input type="checkbox"/> 19. Swelling of ankles |
| | <input type="checkbox"/> 20. Heart murmur |
| <input type="checkbox"/> 3. Do you have: | Have you had: |
| <input type="checkbox"/> Retinal disease | <input type="checkbox"/> 21. Heart attack |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> 22. Stroke |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> 23. Rheumatic fever |
| <input type="checkbox"/> 4. Do you use eye medicine? | <input type="checkbox"/> 24. Heart failure |
| <input type="checkbox"/> 5. Have you had eye surgery? | <input type="checkbox"/> 25. Heart surgery/Stent/Pacemaker |
| <input type="checkbox"/> 6. Have you had laser exposure? | |

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 [] Streptomycin [] 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

2. Have you *ever had* any of the following conditions?

a. Seizures (fits) <input type="checkbox"/> yes <input type="checkbox"/> no	b. Diabetes (sugar disease): <input type="checkbox"/> yes <input type="checkbox"/> no	c. Trouble smelling odors: <input type="checkbox"/> yes <input type="checkbox"/> no
d. Claustrophobia (fear of closed-in places) <input type="checkbox"/> yes <input type="checkbox"/> no	e. Allergic reaction that interfere with your breathing? <input type="checkbox"/> yes <input type="checkbox"/> no	

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

a. Asbestosis <input type="checkbox"/> yes <input type="checkbox"/> no	b. Asthma <input type="checkbox"/> yes <input type="checkbox"/> no	c. Chronic bronchitis <input type="checkbox"/> yes <input type="checkbox"/> no
d. Emphysema <input type="checkbox"/> yes <input type="checkbox"/> no	e. Pneumonia <input type="checkbox"/> yes <input type="checkbox"/> no	f. Tuberculosis <input type="checkbox"/> yes <input type="checkbox"/> no
g. Silicosis <input type="checkbox"/> yes <input type="checkbox"/> no	h. Pneumothorax (collapsed lung) <input type="checkbox"/> yes <input type="checkbox"/> no	i. Lung cancer <input type="checkbox"/> yes <input type="checkbox"/> no
j. Broken ribs <input type="checkbox"/> yes <input type="checkbox"/> no	k. Any chest injuries or surgeries <input type="checkbox"/> yes <input type="checkbox"/> no	l. Any other lung problem you've been told about <input type="checkbox"/> yes <input type="checkbox"/> 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 <input type="checkbox"/> yes <input type="checkbox"/> no	b. Stroke: <input type="checkbox"/> yes <input type="checkbox"/> no
c. Angina <input type="checkbox"/> yes <input type="checkbox"/> no	d. Swelling in your legs and feet (not caused by walking) <input type="checkbox"/> yes <input type="checkbox"/> no
e. Heart Failure <input type="checkbox"/> yes <input type="checkbox"/> no	f. Heart arrhythmia (irregular heart beat) <input type="checkbox"/> yes <input type="checkbox"/> no

g. High blood pressure <input type="checkbox"/> yes <input type="checkbox"/> no	h. Any other heart problem that you've been told about: <input type="checkbox"/> yes <input type="checkbox"/> no
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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 <input type="checkbox"/> yes <input type="checkbox"/> no	Heart trouble <input type="checkbox"/> yes <input type="checkbox"/> no	Blood Pressure <input type="checkbox"/> yes <input type="checkbox"/> no	Seizures (fits) <input type="checkbox"/> yes <input type="checkbox"/> no
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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: <input type="checkbox"/> yes <input type="checkbox"/> no	b. Skin allergies or rashes: <input type="checkbox"/> yes <input type="checkbox"/> no
c. Anxiety <input type="checkbox"/> yes <input type="checkbox"/> no	d. General weakness or fatigue: <input type="checkbox"/> yes <input type="checkbox"/> 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: <input type="checkbox"/> yes <input type="checkbox"/> no	b. Wear glasses: <input type="checkbox"/> yes <input type="checkbox"/> no
c. Color blind: <input type="checkbox"/> yes <input type="checkbox"/> no	d. Any other eye or vision problem: <input type="checkbox"/> yes <input type="checkbox"/> 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

5. List your previous occupations:

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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 <input type="checkbox"/> yes <input type="checkbox"/> no	b. Canisters (e.g. gas masks) <input type="checkbox"/> yes <input type="checkbox"/> no	c. Cartridges <input type="checkbox"/> yes <input type="checkbox"/> no
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11. How often are you expected to use the respirator:

a. Escape only; no rescue <input type="checkbox"/> yes <input type="checkbox"/> no	b. Emergency rescue only <input type="checkbox"/> yes <input type="checkbox"/> no
c. Less than 5 hours per week <input type="checkbox"/> yes <input type="checkbox"/> no	d. Less than 2 hours per day <input type="checkbox"/> yes <input type="checkbox"/> no
e. 2 to 4 hours per day <input type="checkbox"/> yes <input type="checkbox"/> no	f. Over 4 hours per day <input type="checkbox"/> yes <input type="checkbox"/> 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