

Audio History Form

Frederick County Fire Fighters

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 Used sometimes

1/2 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | 25. Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Draining Ear | <input type="checkbox"/> Yes <input type="checkbox"/> No | 26. Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Dizziness/imbalance | <input type="checkbox"/> Yes <input type="checkbox"/> No | 27. Meningitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Severe ringing | <input type="checkbox"/> Yes <input type="checkbox"/> No | 28. Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Sudden hearing loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | 29. Kidney disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Fluctuating hearing loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | 30. Visible wax/object | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Fullness/discomfort | <input type="checkbox"/> Yes <input type="checkbox"/> No | 31. Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. History of prior disease/ear problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | 32. Family hearing loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Recent prescription drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No | 33. High noise exposure today | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | 34. History of prior ear disease before test | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. See MD for ears | <input type="checkbox"/> Yes <input type="checkbox"/> No | 35. Head cold today | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Ear surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | 36. Military service | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22. Unconsciousness | <input type="checkbox"/> Yes <input type="checkbox"/> No | 37. Noisy hobbies | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23. Wear hearing aid | <input type="checkbox"/> Yes <input type="checkbox"/> No | 38. Loud music/headphones | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 24. Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | 39. Firearms/guns | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Explain any 'Yes' responses:

MEDICATIONS (Past & Present) (Please check appropriate boxes.)

- Aspirin, Bufferin, Excedrin (more than 6/day)
- Neomycin Streptomycin Gentamycin Quinine

Explain any checked answers:

Employee Signature

Date

OTOSCOPIC EXAM:

Right: Normal Abnormal _____ Examiners Initials _____

Left: Normal Abnormal _____ Examiners Initials _____

Comprehensive Medical History

Frederick County Fire Fighters

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

Last Tetanus booster: _____
Current Medications: _____

Current Physician: _____

Medical Illnesses - check all that apply:

High Blood Pressure Heart Disease
 Lung Disease Kidney Disease
 Diabetes Anemia
 Seizures 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)

- | | |
|--|--|
| <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 |
|
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

OSHA Mandatory Respirator Medical Evaluation Questionnaire
29 CFR 1910.134

Frederick County Fire Fighters

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 Male Female
8. Your Height: ___ feet ___ inches
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?
- a. Breathing problems yes no
 - b. Heart trouble yes no
 - c. Blood Pressure yes no
 - d. Seizures (fits) 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. Never Used
- a. Eye Irritation: yes no
 - b. Skin allergies or rash yes no
 - c. Anxiety yes no
 - d. General weakness or face: 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 your 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 your 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: | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| b. Silica: | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| c. Tungsten/Cobalt: | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| d. Beryllium: | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| e. Aluminum: | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| f. Coal: | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| g. Iron: | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| h. Tin: | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| i. Dusty environment | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| j. Any other hazardous exposures: | <input type="checkbox"/> yes | <input type="checkbox"/> 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 | <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 |

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:

PLHCP Signature

Date

Respirator Medical Clearance Form

Frederick County Fire Fighters

Please check Type(s) of Respirator(s) to be used:

Air Purifying:

- Negative Pressure (half face or full face)
- PAPR (full face or hood)
- N95 Particulate Respirator

Atmosphere Supplying:

- Airline (continuous flow)
- SCBA (positive pressure, pressure demand)
 - open circuit
 - closed circuit rebreather)
- Combined (airline/SCBA)

Level of Work Effort: Light Moderate Heavy Strenuous

Extent of Usage:

- On a daily basis
- Occasionally - but more than once a week
- Rarely - or for emergency situations only

Length of Time of Anticipated Effort in Hours: _____

Special Work Considerations: (i.e. high places, temperature, hazardous material, protective clothing, etc.)

Company Safety Representative

Telephone Number

Health Care Provider's Evaluation

Class (check one):

- No restrictions on respirator use
- Some specific use restrictions
- No respirator use permitted
- Need special frames for glasses if required to wear full-face respirator
- No contact lenses

Restrictions:

[] FIT TEST TECHNICIAN HAS CONFIRMED THAT FACIAL HAIR IS NOT PRESENT ACROSS RESPIRATOR SEAL AREAS AT THE TIME OF TESTING (OSHA REG 29 CFR 1910.134)

Health Care Provider Signature

Date

Patient Information

CIPRO (ciprofloxacin)
ORAL TABLET 500mg

Frederick County Health Department: 24-hour
Information Telephone Number: 301-600-1029

This drug treats infections. It belongs to a class of drugs called quinolone antibiotics.

You have been given this drug for protection against possible exposure to an infection-causing bacteria.

This drug treats:

- Anthrax

You have been provided a limited supply of medicine. Local emergency health workers or your healthcare provider will inform you if you need more medicine after you finish this supply. If so, upon your follow-up visit, you will be told how to get more medicine. You will also be told if no more medicine is needed.

Take this medicine as prescribed. One tablet by mouth, two times a day.

You will be provided special dosing instructions for children.

Keep taking your medicine, even if you feel okay, unless your doctor tells you to stop. If you stop taking this medicine too soon, you may become infected, or your infection may come back.

You should take this medicine with a full glass of water. Drink several glasses of water each day while you are taking this medicine. It is best to take this medicine 2 hours after a meal. If it upsets your stomach, you may take it with food, but do not take it with milk, yogurt, or cheese. If you miss a dose, take the missed dose as soon as possible. If it is almost time for your next regular dose, wait until then to take your medicine, and skip the missed doses. Do not take two doses at the same time.

DRUGS AND FOODS TO AVOID: Do not take the following drugs within 2 hours of taking CIPRO: antacids such as Maalox or Mylanta, vitamins, iron supplements, zinc supplements, or sucralfate (Carafate). You may take them 2 hours after or 6 hours before CIPRO. Also, make sure your doctor knows if you are taking asthma medicine like theophylline, gout medicine like probenecid (Benemid), or a blood thinner such as Coumadin.

Avoid drinking more than one or two caffeinated beverages (coffee, tea, soft drinks) per day. Avoid taking this medicine with foods containing large amounts of calcium, like milk, yogurt or cheese.

WARNINGS: If you have epilepsy or kidney disease, or if you are pregnant, become pregnant, or are breastfeeding, tell emergency healthcare workers before you start ciprofloxacin or other quinolone medicines such as norfloxacin (Norosin), ofloxacin (Floxin) or nalidixic acid (NegGram).

This medicine may make you dizzy or lightheaded. Avoid driving or using machinery until you know how it will affect you. This medicine increases the chance of sunburn; make sure to use sunscreen to protect your skin.

SIDE EFFECTS: Call your doctor or seek medical advice right away if you are having any of these side effects: rash or hives; swelling of face, throat, or lips; shortness of breath or trouble breathing; seizures; or severe diarrhea. Less serious side effects include nausea, mild diarrhea, stomach pain, dizziness, and headache. Talk with your doctor if you have problems with these side effects.

Patient Information

DOXYCYCLINE 100MG
ORAL TABLET

Frederick County Health Department: 24-hour Information
Information Telephone Number: 301-600-1029

This drug treats infections. It belongs to a class of drugs called tetracycline antibiotics. You have been given this drug for protection against possible exposure to an infection-causing bacteria.

This drug treats:

- Anthrax

You have been provided a limited supply of medicine. Local emergency health workers or your healthcare provider will inform you if you need more medicine after you finish this supply. If so, upon your follow-up visit, you will be told how to get more medicine. You will also be told if no more medicine is needed.

Take this medicine as prescribed. One tablet by mouth, two times a day.

You will be provided special dosing instructions if you have a child under 8 years of age. Keep taking your medicine, even if you feel okay, unless your healthcare provider tells you to stop. If you stop taking this medicine too soon, you may become infected, or your infection may come back.

You may take your medicine with or without food or milk, but food or milk may help you avoid upset stomach.

If you miss a dose, take the missed dose as soon as possible. If it is almost time for your next regular dose wait until then to take your medicine, and skip the missed dose. Do not take two doses at the same time.

DRUGS AND FOOD TO AVOID: Do not take the following medicines within 2 hours of taking DOXYCYCLINE: antacids such as Maalox or Mylanta, calcium or iron supplements, cholestyramine (Questran) or colestipol (Colestid).

While you are taking this medicine, birth control pills may not work as well; make sure to use another form of birth control.

WARNINGS: If you have liver disease, or if you are or might be pregnant, or if you are breastfeeding, tell emergency healthcare workers before you start taking this medicine.

This medicine increases the chance of sunburn; make sure you use sunscreen to protect your skin. Do not take this medicine if you have had an allergic reaction to any tetracycline antibiotics. Women may have vaginal yeast infections from taking this medicine.

SIDE EFFECTS: Call your doctor or seek medical attention right away if you are having any of these side effects: skin rash, hives, or itching; wheezing or trouble breathing; swelling of the face, lips, or throat. Less serious side effects include diarrhea, upset stomach, nausea, sore mouth or throat, sensitivity to sunlight, or itching of the mouth or vagina lasting more than 2 days. Talk with your doctor if you have problems with these side effects.

