

Frederick Health Employer Solutions
Phone: 240-566-3001

Patient Name: _____ Social Security #: _____ Company: _____ Date of Service: _____
 Birthdate: ___/___/___ Age: _____ Form: F-AUDIO Page 1 of 1

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 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 _____
 f-audio

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MEDICAL HISTORY-COMPREHENSIVE

WHAT IS YOUR HOME COMPANY #: _____
LIST ANY OTHER CARROLL AFFILIATIONS: _____
Allergies: Latex: Yes _____ No _____
Medication Allergies: _____
Other Allergies: _____
Last Tetanus booster: _____ Current Physician: _____
Current Medications: _____

Medical Illnesses (check all that apply):
 High Blood Pressure Heart Disease Lung Disease Diabetes
 Anemia Kidney Disease 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
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? _____
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 _____

Liver or Gastrointestinal Blood, Endocrine
Do you have or have you had: Have you had:

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MEDICAL HISTORY-COMPREHENSIVE

- 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
 55. Paralysis
 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

- 63. Anemia
- 64. Bleeding problems
- 65. Hormone problems
- 66. Diabetes
- 67. Thyroid problem

Musculoskeletal
Have you had or do you have:
 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:

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MEDICAL HISTORY-COMPREHENSIVE

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
f-hxccff

Date

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Patient Name: _____ Social Security #: _____ Company: _____ Date of Service: _____

Birthdate: ___/___/___ Age: _____ Form: F-RESHXM

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RESPIRATOR QUESTIONNAIRE

OSHA Mandatory Respirator Medical Evaluation Questionnaire
29 CFR 1910.134

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. Your Job Title: FIREFIGHTER AND/OR EMT
5. Your Date of Birth: ___/___/___
6. Sex Male Female
7. Your Height: ___ feet ___ inches
8. Your Weight: ___ lbs.
9. Phone # where you can be reached to discuss your answers: (_____) _____
10. The best time to call you at this number:
_____ a.m. p.m.
11. Has your employer told you how to contact the health care professional who will review this questionnaire? yes no
12. 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).
13. Have you worn a respirator? yes no
If yes, what type(s):
OPEN CIRCUIT SCBA

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

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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 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

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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:

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RESPIRATOR QUESTIONNAIRE

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 environments: | <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:

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RESPIRATOR QUESTIONNAIRE

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
VARIABLE 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:
STRUCTURAL FIREFIGHTING TURNOUT GEAR
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 POSSIBLE
16. Describe the work you'll be doing while you're using your respirator(s):
INTERIOR STRUCTURAL FIREFIGHTING

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17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (e.g., confined spaces, life-threatening gases):
HAZARDS ASSOCIATED WITH INTERIOR STRUCTURAL FIREFIGHTING

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: _____ SPECIFIC SUBSTANCES UNKNOWN OR
Estimated maximum exposure level per shift: _____ VARIABLE BY SITUATION
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)
WILL WORK AS PART OF A FIREFIGHTING TEAM; MAY EFFECT RESCUE OPERATIONS

Employee Signature

Date

OSHA Mandatory Respirator Medical Evaluation Questionnaire Reviewed by:

PLHCP Signature
f-reshxm

Date