

Carroll Occupational Health

Patient: _____ Company: _____ Date of Service: _____
Patient ID: _____ Contact: _____
Birthdate: ___/___/___ Age: ___ Form: F-AUDIO Page 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 [] 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/object [] 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' 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

Carroll Occupational Health

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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 ___ 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)

- 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?

Respiratory

- Do you have:
26. Chronic cough
27. Asthma
28. Bronchitis
29. Hay fever
30. Emphysema/COPD
Have you had:

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Medical History-Comprehensive

- 13. Ruptured ear drum?
- 14. Exposure to gunfire?
- 15. Wear hearing protection?

- 31. Tuberculosis
- 32. Lung cancer
- 33. Lung surgery
- 34. Silicosis
- 35. Asbestos
- 36. Black lung

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?

Blood, Endocrine
Have you had:

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

Genitourinary:
Do you or have you had:

- 46. Kidney trouble
- 47. Bladder trouble
- 48. Kidney stones

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

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

Communicable Diseases:
Have you had:

- 81. Chicken pox
- 82. Measles
- 83. German Measles
- 84. Mumps
- 85. Hepatitis A
- 86. Hepatitis B
- 87. Hepatitis C

Are you taking medication for:

- 60. Anxiety or depression
- 61. Epilepsy
- 62. Parkinson's disease

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: _____

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Medical History-Comprehensive

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

Carroll Occupational Health

Patient: _____ Company: _____ Date of Service: _____
 Patient ID: _____ Contact: _____
 Birthdate: ___/___/___ Age: _____ Form: F-RESHXM Page 1

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). yes no
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

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- 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

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RESPIRATOR QUESTIONNAIRE

- 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:
- 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
 - yes no
 - yes no
 - 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

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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:

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RESPIRATOR QUESTIONNAIRE

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
 VARIABLE hours _____ minutes

Examples of heavy work are lifting a heavy load (about 50 lbs.) from the
 floor to

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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

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:

--

Carroll Occupational Health

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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-reshtm

Date