Post-Offer Health History and Respirator Medical Questionnaire

(Confidential)

Last Name	First Name	M.I.	M☐ F☐	Social Security Number

Home Address	City	State	Zip	Phone Number	Date of Birth

Work Location	Department Name	Job Title

Please let a Human Resources representative know if you need help reading or completing this form.

PERSONAL / WELLNESS

SECTION I:

Have you ever had any of the following diseases?

YES	NO	
☐	☐	Chicken Pox
☐	☐	Tuberculosis
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	Hepatitis, any type

Have you been vaccinated for:

YES	NO		
☐	☐	Hepatitis B Series	Date: _____
		Number of Hepatitis B shots:	_____
☐	☐	Was a blood test done after the shots to determine immunity?	
		Date and test results:	_____
☐	☐	Tetanus Immunization	Date: _____

1. Do you have a condition that places you at a greater risk to contract an infectious disease (are you immune compromised)?
☐ No ☐ Yes Please explain Yes answer: _____
2. Have you had any surgeries? ☐ No ☐ Yes Please explain Yes answer including date: _____
3. Name of your Primary Care Physician (family doctor): _____
4. Please list any other physicians or specialists you have seen in the past 5years: _____
5. Have you used tobacco products in the past 6 months (i.e., cigarettes, cigars, pipes, chewing tobacco, e-cigarettes,etc.)? ☐ No ☐ Yes
6. Please list all current prescriptions and over-the-counter medications you have taken in the past 30 days: _____

Name

SECTION II: **HEALTH HISTORY**

	Do you currently have or have you ever had:	Yes Now	Yes Past	No Never
Head and Neck	10. Nose or sinus problems	☐	☐	☐
	11. Frequent sore throats	☐	☐	☐
	12. Problems with or loss of smell/taste*	☐	☐	☐
	13. Eye injuries or problems	☐	☐	☐
	14. Head injury	☐	☐	☐
	15. Hearing problem, loss or injury*	☐	☐	☐
	16. Ringing or noise in your ears	☐	☐	☐
	17. Vision difficulty in either eye/legally blind*	☐	☐	☐
	18. Neck pain or injury	☐	☐	☐
	19. Thyroid problems	☐	☐	☐
Musculoskeletal	20. Joint pain, swelling or fibromyalgia	☐	☐	☐
	21. Decreased motion in any joint, arms or legs*	☐	☐	☐
	22. Loss of muscle strength or muscle problems	☐	☐	☐
	23. Back pain or injury*	☐	☐	☐
	24. Herniated disc	☐	☐	☐
	25. Hip or leg pain or injury	☐	☐	☐
	26. Knee pain or injury	☐	☐	☐
	27. Foot trouble	☐	☐	☐
	28.Shoulder, elbow, hand or wrist pain or injury	☐	☐	☐
	29. Weakness in arms, hands, legs or feet*	☐	☐	☐
	30. Tendon or ligament problem	☐	☐	☐
Neurological	31. Parkinson's Disease or Multiple Sclerosis	☐	☐	☐
	32. Paralysis	☐	☐	☐
	33. Tremors or shaking	☐	☐	☐
	34. Head injury or migraine headaches	☐	☐	☐
	35. Seizures	☐	☐	☐
	36. Balance problems or dizziness	☐	☐	☐
	37. Fainting or loss of consciousness	☐	☐	☐
	38. Sleep apnea or sleep disorder	☐	☐	☐

	Do you currently have or have you ever had:	Yes Now	Yes Past	No Never
Immune System	39. Frequent infections	☐	☐	☐
	40. Herpes / cold sores	☐	☐	☐
	41. Immune system problems	☐	☐	☐
	42. Recurrent fevers, chills or sweats	☐	☐	☐
	43. History of Tuberculosis	☐	☐	☐
	44. Abnormal chest X-ray	☐	☐	☐
	45. Positive TB Skin Test	☐	☐	☐
	46. Chicken pox / shingles	☐	☐	☐
	47. Unexplained weight loss or gain	☐	☐	☐
	48. Implanted metal ie. wires, rods or shrapnel	☐	☐	☐
Other Conditions	49. Cancer or tumor	☐	☐	☐
	50. Blood problems or blood clots	☐	☐	☐
	51. Hemophilia	☐	☐	☐
	52. Varicose veins	☐	☐	☐
	53. Kidney stones or kidney disease	☐	☐	☐
	54. Jaundice or liver disease	☐	☐	☐
	55. Eczema or other rash problems	☐	☐	☐
	56. Rupture or hernia	☐	☐	☐
	57. Stomach or intestinal pain	☐	☐	☐
	58. Ulcers or frequent indigestion	☐	☐	☐
	59. Diabetes ie. sugar disease*	☐	☐	☐
	60. Recurrent constipation or diarrhea	☐	☐	☐
	61. Recurrent nausea or vomiting	☐	☐	☐
	62. Birth defects	☐	☐	☐
	63. Physical, mental or learning disabilities	☐	☐	☐
	64. Psychiatric treatment or illness	☐	☐	☐
	65. Alcohol/drug dependency or treatment	☐	☐	☐
	66. Depression or anxiety disorder	☐	☐	☐

	67. Are you currently receiving medical treatment? *If yes, please explain for what and for how long below.*	☐	☐	☐
	68. Have you been seen in the past 2 years by a chiropractor or received physical therapy or other alternative treatments?	☐	☐	☐
	69. Have you ever sustained injuries from a motor vehicle accident?	☐	☐	☐
	70. Have you ever received compensation for sickness or injury?	☐	☐	☐
	71. Have you been given a Perm Impairment Rating from a motor vehicle accident or Workers' Compensation claim?	☐	☐	☐
	72. Have you been given permanent work restrictions or do you have a disability?	☐	☐	☐
	73. Do you need any accommodations for any restriction, limitation or disability?	☐	☐	☐

PLEASE EXPLAIN ALL "YES NOW" OR "YES PAST" ANSWERS FROM *SECTION II* HERE(use additional sheets if necessary):

Name _____

SECTION III: **OSHA RESPIRATORY & CARDIAC QUESTIONS***

A Human Resources Representative will review this questionnaire. You MUST answer each question.

Have you ever had any of the following lung problems?	Yes	No
Asbestos	☐	☐
Asthma	☐	☐
Broken Ribs	☐	☐
Chronic Bronchitis	☐	☐
Lung Cancer	☐	☐
Pneumonia	☐	☐
Pneumothorax (collapsed lung)	☐	☐
Emphysema	☐	☐
Silicosis	☐	☐
Any chest injuries/surgeries	☐	☐
Any other lung problems	☐	☐

Have you ever had any of the following heart problems?	Yes	No
Heart attack	☐	☐
Stroke	☐	☐
Angina	☐	☐
Heart failure	☐	☐
Swelling in your legs or feet NOT caused by walking	☐	☐
Irregular heartbeat	☐	☐
High blood pressure	☐	☐
Other heart problem or symptom	☐	☐

Are you taking medication for any of the following problems?	Yes	No
Heart trouble	☐	☐
Blood pressure	☐	☐
Seizures	☐	☐
Vascular or heart problem	☐	☐
Any breathing or lung problem	☐	☐

Do you have any of the following lung symptoms?	Yes	No
Shortness of breath	☐	☐
Short of breath walking FAST on level ground or uphill	☐	☐
Short of breath walking NORMAL pace on level ground or uphill	☐	☐
Do you stop for breath when walking at a normal pace on level ground?	☐	☐
Chest pain with deep breaths	☐	☐
Short of breath when washing or dressing yourself	☐	☐
Shortness of breath that interferes with your job	☐	☐
Coughing that produces thick sputum	☐	☐
Coughing that wakes you early in the morning	☐	☐
Coughing that occurs mostly when you are lying down	☐	☐
Have you coughed up blood in the last month?	☐	☐
Wheezing	☐	☐
Wheezing that interferes with your job	☐	☐
Any other breathing or lung symptom	☐	☐

Have you ever had any of the following heart symptoms?	Yes	No
Frequent chest pain or tightness	☐	☐
Chest pain or tightness with physical activity	☐	☐
Heartburn or indigestion not related to eating	☐	☐

Do you have any vision problems?	Yes	No
Wear contact lenses	☐	☐
Wear glasses	☐	☐
Color blind	☐	☐
Any other eye or vision problems	☐	☐

Do you have any of the following hearing problems?	Yes	No
Ruptured ear drum	☐	☐
Wear a hearing aid	☐	☐
Any hearing problem	☐	☐

Musculoskeletal questions for employees wearing SCBA or full-face respirators:

☐ *Check here if N/A; skip to section IV*

Pain or stiffness when you lean forward or backward	☐	☐
Difficulty moving your head up and down	☐	☐
Difficulty moving your head side to side	☐	☐
Difficulty bending at the knees	☐	☐
Difficulty squatting to the ground	☐	☐
Difficulty climbing a flight of stairs or ladder carrying 25 lbs.	☐	☐
Any other muscle/skeletal problems interfering with use of a respirator or other job duties	☐	☐

Describe any special or hazardous condition you may be exposed to while wearing your respirator:

Are you aware of any toxic substance you expect to work with and for which you will need to wear a respirator? ☐ Yes ☐ No

Please list any known substances and the expected time you will work with the substances in an eight-hour day:

Describe any special responsibility you will have while using the respirator that may affect the safety and well-being of others (examples: rescue, security):

PLEASE EXPLAIN ALL "YES" ANSWERS FROM *SECTION III* HERE:

Name _____

Respirator Medical Evaluation*

1. Check the type of respirator you will use (you can check more than one category):
   - ☐ N, P, or R disposable respirator (filter-mask, non-cartridge type only)
   - ☐ Other type (for example, half- or full-face piece type, powered air purifying, supplied-air)
2. Have you ever worn a respirator? ☐ No ☐ Yes Type: _____
3. If you have worn a respirator, please indicate any problems you've ever experienced:
   Eye irritation ☐ Anxiety ☐ Skin Allergies ☐ General weakness or fatigue ☐ Other problems ☐

	Yes	No	
4.	☐	☐	Have you ever had allergic reactions that interfere with your breathing?
5.	☐	☐	Have you ever had claustrophobia (fear of closed in places)?

SECTION IV: OCCUPATIONAL HISTORY

A. Fill in the following regarding your last three jobs: 1.) Fill in the job title. 2.) Fill in the number of hours you routinely worked per week. 3.) Fill in the industry you worked in (for example: construction, mining, oil exploration, chemical, auto repair, healthcare, hospitality, military, government, etc.) 4.) Fill in the number of years in the specified job. 5.) List any exposures including heavy lifting, repetitive motions, radiation, chemicals, vapors, fumes, dust, or smoke. 6.) List any health problems you experienced as a result of the particular job.

1. Job Title	2. Hours/Week	3. Industry	4. Date/Yrs Worked	5. Potential Exposures	6. Health Problems

B. Please list **ANY and/or ALL** on-the-job injuries, illness or accidents that you have experienced. (Use additional sheets if necessary)

_____ **Initial here if you have NEVER had an on-the-job (work-related) injury, accident or illness:**

Injury Date	Injury Type	Body Part	# Workdays Lost	Medical Care	Status of Case

C. Do you have a second job?* ☐ No ☐ Yes Please describe: _____

SECTION V: ACKNOWLEDGEMENT

I certify that this health history is true and complete and that I do not have any illness, injury, or chronic disease other than stated within this document. I understand that falsification of and/or failure to provide any information is grounds for immediate dismissal or could result in denial of workers compensation benefits. I also understand that the job offer is contingent upon successful completion of and verification of data provided in the post offer screening. I authorize medical information obtained during my screening may be disclosed, only to the extent necessary to determine my ability to perform essential functions of my intended position. I understand that this screening is completed to determine my ability to perform essential functions of my intended position and does not constitute a complete and comprehensive medical examination. It is not intended for use to determine the status of my overall personal health.

_____ _____

Employee Signature Date

All questions designated with an asterisk (*) are required under OSHA's Respiratory Protection Standard.