

**Montgomery County Government
Fire/Rescue Occupational Medical Services
Medical History Form for Assessing Readiness
For Respirator Mask Fitting**

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

Can you read (circle one): Yes/No

Note to employer: If the employee indicates he/she cannot read, he/she is to be referred to OMS for assistance in completing the questionnaire.

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place 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.

Please read: Please complete this questionnaire during your work hours. Be sure to answer all questions as thoroughly as possible. When you have finished, place the form in an envelope marked 'Confidential', seal it, and send it to Occupational Medical Services [OMS]. If the Employee Medical Examiner determines an examination is necessary, you will be notified to schedule an appointment.

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: _____ Your name: _____
- 2. Fire Service Number: _____ Social Security #: _ _ _ - _ _ - _ _ _ _
- 3. Your age (to nearest year): _____ 4. Sex (circle one): Male/Female
- 5. Your height: ____ ft. ____ in. 6. Your weight: ____ lbs.
- 7. Your job title: _____ Sta #: _____ Dept. Contact: _____
- 8. A phone number where you can be reached by OMS: _____
- 9. The best time to phone you at this number: _____
- 10. Your Address (street, state, zip code) _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

- 11. 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-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): Yes/No

If "yes," what type(s): _____

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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 (please circle "yes" or "no").

If you answer YES to any of the questions below, please give a detailed explanation of what the issue was, when it occurred and what the outcome was.

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. Allergic reactions that interfere with your breathing

Yes No

d. Claustrophobia (fear of closed-in places)

Yes No

e. Trouble smelling odors

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 that 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

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- | | | |
|--|-----|----|
| 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. Heart failure | Yes | No |
| e. Swelling in your legs or feet (not caused by walking) | Yes | No |
| f. Heart arrhythmia (heart beating irregularly) | 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 your 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 other 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 or lung 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 space and go to question 9:) ____
- | | | |
|--|-----|----|
| 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 |

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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-face piece 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 |
| e. Any other eye or vision problem | Yes | No |

12. Have you **ever had** an injury to your ears, including a broken ear drum? 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 and 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 feet) or in a place that has lower than normal amounts of oxygen? Yes No

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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 | Yes | No |
| b. Silica (e.g., in sandblasting) | Yes | No |
| c. Tungsten/cobalt (e.g., grinding or welding this material) | Yes | No |
| d. Beryllium | Yes | No |
| e. Aluminum | Yes | No |
| f. Coal (for example, mining) | 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 these exposures: _____

4. List any second jobs or side businesses you have: _____

5. List your previous occupations: _____

6. List your current and previous hobbies: _____

7. Have you been in the military services? Yes No

If "yes," were you exposed to biological or chemical agents (either in training or combat)? Yes No

8. Have you ever worked on a HAZMAT team? Yes No

9. Other than 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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10. Will you be using any of the following items with your respirator(s)?

- | | | |
|---------------------------------------|-----|----|
| a. HEPA Filters | Yes | No |
| b. Canisters (for example, gas masks) | Yes | No |
| c. Cartridges | Yes | No |

11. How often are you expected to use the respirator(s)? (Circle "yes" or "no" for all answers that apply to you)

- | | | |
|--------------------------------------|-----|----|
| 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? ___ hrs. ___ mins.

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 ___ hrs. ___ mins.

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 ___ hrs. ___ mins.

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.).

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13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator? Yes No

If "yes," describe this protective clothing and/or equipment: _____

14. Will you be working under hot conditions (temperature exceeding 77 deg. 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) (for example, 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 the first toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the second toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the third toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

The name of any other toxic substances that you'll be exposed to while using your respirator: _____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue or security):

I certify that all answers are complete and accurate to the best of my knowledge:

Signature _____

Date _____