WORKPLACE HEALTH SERVICE
A Service of Wyoming County Community Health System
408 North Main Street Warsaw, NY 14569 (585) 786-8940, ext. 4549

Annual Respiratory/Fire Questionnaire

Name: _____ Date of Birth: _____

Complete Mailing Address: _____
Street/PO Box City State Zip Code

Home Phone: _____ Cell Phone: _____

Best phone number to reach you: _____ Best time: _____ AM/PM

Family Physician/Provider: _____

Relative/Contact: _____ Relation: _____

Contact Phone No.: _____ **Allergies:** _____
(Food, medicine, environmental, etc.)

PURPOSE

The purpose of this evaluation is to screen you for communicable diseases and to determine whether you have any physical, mental, or emotional impairment that could affect your ability to perform the job that you have been offered. Whenever such impairment is identified, we will attempt to specify restrictions that may allow you to perform the job safely while still successfully performing the essential functions of the job. We also will identify certain behaviors or characteristics, which should not affect your job status but could adversely affect your future health. Thus, this evaluation is not a comprehensive medical examination to identify hidden disease or to offer medical treatment. Once you have begun your job, we encourage you to establish a relationship with a medical provider in accordance with age-appropriate guidelines and your specific needs.

AUTHORIZATION FOR TREATMENT

I certify that the following information is true to the best of my knowledge. I understand and agree to authorize Workplace Health Service to review any information (including, but not limited to, information relating to psychiatric/psychological and alcohol and drug diagnosis and treatment, if any such information exists) of health care providers regarding me for purposes related to my fitness for employment. I agree to any reasonable subsequent testing or evaluation deemed necessary to determine my fitness to perform this job, and I authorize the examining provider to forward pertinent information to those who would perform such testing or evaluation. I understand that certain immunizations and TB skin testing are potentially required for employment and consent to the administration of these as required. I further understand that misrepresenting facts called for above may forfeit this employment opportunity and/or cause termination at any time during employment. I understand that this record will become part of my Employee Health file.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize WCCH Workplace Health Services to release to my employer/company: _____ a copy of all examinations and evaluations completed. Workplace Health Services is released from all legal responsibility which may arise from the release of requested information.

Permission to fax or email information to employer [ ] YES [ ] NO
This authorization will expire six months from the date of signing.

Applicant Signature: _____
Date

Under Age 18:
You are required by law to have your parent or guardian co-sign for your examination.

Parent/Guardian Signature: _____
(Authorizing treatment and release of medical information) Date

PERSONAL HISTORY

Current Medications: _____

_____

_____

Tobacco Use: Do you currently smoke/chew tobacco, or have you smoked tobacco in the past: Yes No
If yes, how much each day: _____ for how long: _____

Alcohol Use: _____ Yes _____ No Daily/Occasionally/Socially (circle one)
Type/Amount per Day: _____

MEDICAL/FUNCTIONAL SELF-ASSESSMENT

Have you **ever** been hospitalized or had **any** surgeries (include dates)? Yes No
If yes, please list all: _____

_____

_____

Are you **currently** being treated for any medical problems? Yes No
If yes, please list all: _____

_____

As a result of an injury, surgery, illness or other cause, as arthritis, do you have **or** ever had **any impairment/ disability/decreased function** including pain, numbness, weakness or loss of sensation in any of the following:

Either shoulder/arm/hand, including grip/reach, use of fingers	Yes	No
Hips, knees, ankles, or feet	Yes	No
Neck, upper, middle, or lower back	Yes	No

If yes to any of the above, please explain: _____

_____

_____

Do you **currently** have any of the following vision or hearing problems?

Wear contacts lenses	Yes	No	Difficulty hearing	Yes	No
Wear glasses	Yes	No	Wear a hearing aid	Yes	No
Color blind	Yes	No	Injury to ear/broken eardrum	Yes	No
Any lost vision in either eye (temporary or permanent)				Yes	No
Any other eye, vision, hearing, or ear problem				Yes	No

If yes to any of the above, please explain: _____

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_____

Do you **have** or **ever had** any of the following conditions or symptoms?

Seizures (fits)	Yes	No	Dizziness	Yes	No
Trouble smelling odors	Yes	No	Anemia	Yes	No
Difficulty sleeping	Yes	No	Fatigue	Yes	No
Liver problems	Yes	No	Headaches	Yes	No
Kidney problems	Yes	No	Claustrophobia	Yes	No
Nausea/vomiting	Yes	No	Sinus problems	Yes	No
Diabetes (sugar)	Yes	No	Skin disease	Yes	No
Cancer	Yes	No	Depression	Yes	No
Hepatitis	Yes	No	Thyroid	Yes	No

If yes to any of the above, please explain: _____

_____

Have you **ever had** any of the following lung (pulmonary) or heart (cardiovascular) problems or symptoms? If yes, please indicate date of last episode.

Asbestosis	Yes	No	Emphysema	Yes	No
Chronic bronchitis	Yes	No	Asthma	Yes	No
Lung cancer	Yes	No	Pneumonia	Yes	No
Tuberculosis	Yes	No	Silicosis	Yes	No
Chest injury/surgery	Yes	No	Broken ribs	Yes	No
Pneumothorax (collapsed lung)	Yes	No	Wheezing	Yes	No
			Stroke	Yes	No
Swelling in feet/legs	Yes	No	Heart attack	Yes	No
Irregular heart beat	Yes	No	Heart failure	Yes	No
High blood pressure	Yes	No	Angina	Yes	No

Shortness of breath?	Yes	No
Shortness of breath when walking fast on level ground or walking up slight hill?	Yes	No
Shortness of breath when walking with other people at an ordinary pace on level ground?	Yes	No
Have to stop for breath when walking at your own pace on level ground?	Yes	No
Shortness of breath when washing or dressing yourself?	Yes	No
Shortness of breath that interferes with your job?	Yes	No
Coughing that produces phlegm (thick sputum)?	Yes	No
Coughing that wakes you early in the morning?	Yes	No
Coughing that occurs mostly when you are lying down?	Yes	No
Coughing up blood in the last month?	Yes	No
Wheezing that interferes with your job?	Yes	No
Chest pain when you breathe deeply?	Yes	No
Allergic reactions that interfere with breathing?	Yes	No
Frequent pain or tightness in your chest?	Yes	No
Pain or tightness in your chest during physical activity?	Yes	No
Pain or tightness in your chest that interferes with your job?	Yes	No
In the past two years, have you noticed your heart skipping or missing a beat?	Yes	No
Heartburn or indigestion that is not related to eating?	Yes	No
Any other lung or heart problem that you have been told about?	Yes	No
Any other symptoms that you think may be related to lung or heart problems?	Yes	No

If yes to any of the above, please explain: _____

_____

_____

Have you **ever** had a back injury? Yes No

If yes, please explain: _____

Do you **currently** have any of the following musculoskeletal problems?

Back pain	Yes	No	Difficulty bending at your knees	Yes	No
Difficulty fully moving your arms and legs	Yes	No	Difficulty squatting to the ground	Yes	No
Difficulty fully moving your head up or down or side to side				Yes	No
Weakness in any of your arms, hands, legs, or feet				Yes	No
Pain or stiffness when you lean forward or backward at the waist				Yes	No
Climbing a flight of stairs or a ladder carrying more than 25lbs.				Yes	No
Any other muscle or skeletal problem that interferes with using a respirator				Yes	No

If yes, please explain: _____

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_____

Type of Respirator:

___ N, R, or P disposable respirator (filter-mask, non-cartridge type only)

___ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

Have you ever worn a respirator? Yes No

If yes, have you **ever had** any of the following problems?

Eye irritation	Yes	No	Anxiety	Yes	No
Skin allergies or rashes	Yes	No	Weakness or fatigue	Yes	No
Any other problem that interferes with your use of a respirator?				Yes	No

If yes, please explain:

_____

Will you be wearing protective clothing and/or equipment when you're using the respirator? Yes No

Will you be working under hot conditions (temperature exceeding 77 degrees Fahrenheit)? Yes No

Will you be working under humid conditions? Yes No

Have all your questions been answered to the best of your understanding? Yes No

I declare each of the answers given to be complete and true, and I am aware that any misrepresentation or omission is cause for dismissal if I am employed.

Applicant Signature_____Date_____ Examiner Initials_____