



NAME \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_  
NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

DEPARTMENT \_\_\_\_\_ POSITION \_\_\_\_\_

Do you have or have you ever had any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Head or Brain Injury            | <input type="checkbox"/> Angina                 | <input type="checkbox"/> Neck injury                                  |
| <input type="checkbox"/> Frequent headaches or dizziness | <input type="checkbox"/> Heart palpitations     | <input type="checkbox"/> Arthritis                                    |
| <input type="checkbox"/> Seizures                        | <input type="checkbox"/> Rheumatic fever        | <input type="checkbox"/> Skin rash/Eczema                             |
| <input type="checkbox"/> Poor hearing                    | <input type="checkbox"/> Swollen/painful joints | <input type="checkbox"/> Varicose Veins                               |
| <input type="checkbox"/> Wear hearing device             | <input type="checkbox"/> Chicken pox            | <input type="checkbox"/> Kidney/ Bladder problems                     |
| <input type="checkbox"/> Blurred vision                  | <input type="checkbox"/> Thyroid disorder       | <input type="checkbox"/> Prostates disease                            |
| <input type="checkbox"/> Glasses/contacts                | <input type="checkbox"/> Ulcers                 | <input type="checkbox"/> Cancer                                       |
| <input type="checkbox"/> Fainting spells                 | <input type="checkbox"/> Heartburn              | <input type="checkbox"/> Blood in sputum, urine or stool              |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Bowel disorder         | <input type="checkbox"/> Depression/anxiety                           |
| <input type="checkbox"/> COPD                            | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Alcohol/drug use                             |
| <input type="checkbox"/> Chronic cough                   | <input type="checkbox"/> HIV positive           | <input type="checkbox"/> Carpal tunnel                                |
| <input type="checkbox"/> Tuberculosis                    | <input type="checkbox"/> Hernia                 | <input type="checkbox"/> Problems with legs ankles or feet            |
| <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Back injury            | <input type="checkbox"/> Test for Tuberculosis in the last year (PPD) |

Have you ever been hospitalized?  Yes  NO

Have you been seriously injured?  Yes  NO

Are you allergic to Latex?  Yes  NO

Have you ever had surgery?  Yes  NO

Do you have any known allergies?  Yes  NO

Have you ever received workers compensation benefits before?  Yes  NO

If you answered yes to any of the above questions please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you feel you are able to meet the physical requirements that your job would require? If no, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height \_\_\_\_\_ft \_\_\_\_\_in Weight \_\_\_\_\_

Pregnant: Yes NO Department \_\_\_\_\_ Job Title \_\_\_\_\_

Have you ever worn a respirator before? Yes NO If Yes, What type? \_\_\_\_\_

Limitations (Check one):  None  Beard  Glasses  Dentures

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes NO  
Pack history: \_\_\_\_\_

2. Have you ever had any of the following conditions? (check if yes)
- Seizures
  - Diabetes
  - Allergic reactions that interfere with your breathing
  - Claustrophobia (fear of closed in spaces)
  - Trouble smelling odors

3. Have you ever had any of the following pulmonary or lung problems? (check if yes)
- Asbestosis
  - Asthma
  - Chronic bronchitis
  - Emphysema
  - Pneumonia
  - Tuberculosis
  - Silicosis
  - Pneumothorax (collapsed lung)
  - Lung cancer
  - Broken ribs
  - Any chest injury or surgeries
  - Any other lung problem that you have been told about

4. Do you have any of the following symptoms of pulmonary or lung illnesses? (check if yes)
- Shortness of breath
  - Shortness of breath when walking fast on level ground or walking slightly up hill
  - Shortness of breath when walking with other people at an ordinary pace on level ground
  - Have to stop for breath when walking at your own pace on level ground
  - Shortness of breath when washing or dressing your self
  - Shortness of breath that interferes with your job
  - Coughing that produces phlegm (thick sputum)
  - Coughing that wakes you up early in the morning
  - Coughing that occurs mostly when you are lying down
  - Coughing up blood in the last month
  - Wheezing
  - Wheezing that interferes with your job
  - Chest pain when you breathe deeply
  - Any other symptom that you think might be related to lung problems



5. Have you ever had any of the following cardiovascular or heart problems? (check if yes)

- Heart attack
- Stroke
- Angina
- Heart failure
- Swelling in your legs or feet (not caused by walking)
- Heart arrhythmia (heart beating irregularly)
- High blood pressure
- Any other heart problem that you've been told about

6. Have you ever had any of the following cardiovascular or heart symptoms? (check if yes)

- Frequent pain or tightness in your chest
- Pain or tightness in your chest during physical activity
- Pain or tightness in your chest that interferes with your job
- In the past two years, have you noticed your heart skipping or missing a beat
- Heartburn or indigestion that is not related to eating
- Any other problems that you think might be related to heart or circulation problems

7. Do you currently take any medications for any of the following problems? (check if yes)

- Breathing or lung problems
- Skin allergies or rashes
- Anxiety
- General weakness or fatigue
- Any other problem that interferes with your use of a respirator

8. If you have used a respirator, have you had any of the following problems? (check if yes)

- Eye irritation
- Skin allergies or rashes
- Anxiety
- General weakness or fatigue
- Any other problems that interferes with your use of a respirator

9. Would you like to talk to the healthcare professional who will review this questionnaire about your answers?      Yes      NO

Employee Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

Approval Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

Mask Size:            Regular            Small

Yes	NO	Satisfactory Qualitative Bitrex Fit Test	Yes	NO	Donning & Removing Mask
Yes	NO	Satisfactory Positive/Negative Pressure Fit Check Test	Yes	NO	Location of Masks for use when needed
Number of Sensitivity Sprays		<5    <10    <15	Number of Fit Test Sprays		5    10    15

**Please check the option below that is appropriate:**

I have already completed the series, therefore I decline it.

I wish to decline the vaccine.

I am interested in taking the vaccine.

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_



NAME \_\_\_\_\_ EMP# \_\_\_\_\_ DOB \_\_\_\_\_

DEPARTMENT \_\_\_\_\_ DATE \_\_\_\_\_

**Tuberculosis Screening**

Have you ever had a TB skin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
Have you ever had a reaction to a TB skin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
Is there a history of Tuberculosis in your family?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
Have you ever taken a medication for Tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
Have you ever had a vaccine called BCG?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
Have you had a MMR or Varicella vaccination in the last 3 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
Have you been treated with steroids in the past month?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
Do you have an immune compromised illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
Were you born in a Country where tuberculosis is common?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
Have you traveled outside of the US in the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
Have you ever or do you currently live in a large group setting? <small>(examples: homeless shelter or correctional facility)</small>	<input type="checkbox"/> Yes	<input type="checkbox"/> NO

**Do you currently have any of the following symptoms?**

Unusual fatigue for more than 2 weeks	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
Weight loss (unrelated to dieting)	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
Loss of appetite for more than 2 weeks	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
Persistent cough longer than 2 weeks	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
Fever associated with cough for more than 1 week	<input type="checkbox"/> Yes	<input type="checkbox"/> NO
Night sweats unrelated to hormone imbalance	<input type="checkbox"/> Yes	<input type="checkbox"/> NO