

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				
Musculoskeletal	19. Thyroid problems				
	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				
Neurological	29. Weakness in arms, hands, legs or feet*				
	30. Tendon or ligament problem				
	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				
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? <i>If yes, please explain for what and for how long below.</i>					
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):					

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	Do you have any of the following lung symptoms?	Yes	No	Do you have any vision problems?	Yes	No
Asbestos			Shortness of breath			Wear contact lenses		
Asthma			Short of breath walking FAST on level ground or uphill			Wear glasses		
Broken Ribs			Short of breath walking NORMAL pace on level ground or uphill			Color blind		
Chronic Bronchitis			Do you stop for breath when walking at a normal pace on level ground?			Any other eye or vision problems		
Lung Cancer			Chest pain with deep breaths					
Pneumonia			Short of breath when washing or dressing yourself			Do you have any of the following hearing problems?		
Pneumothorax (collapsed lung)			Shortness of breath that interferes with your job			Ruptured ear drum		
Emphysema			Coughing that produces thick sputum			Wear a hearing aid		
Silicosis			Coughing that wakes you early in the morning			Any hearing problem		
Any chest injuries/surgeries			Coughing that occurs mostly when you are lying down					
Any other lung problems			Have you coughed up blood in the last month?			Musculoskeletal questions for employees wearing SCBA or full-face respirators: <i>Check here if N/A; skip to section IV</i>		
Have you ever had any of the following heart problems?			Wheezing			Pain or stiffness when you lean forward or backward		
Heart attack			Wheezing that interferes with your job			Difficulty moving your head up and down		
Stroke			Any other breathing or lung symptom			Difficulty moving your head side to side		
Angina			Have you ever had any of the following heart symptoms?			Difficulty bending at the knees		
Heart failure			Frequent chest pain or tightness			Difficulty squatting to the ground		
Swelling in your legs or feet NOT caused by walking			Chest pain or tightness with physical activity			Difficulty climbing a flight of stairs or ladder carrying 25 lbs.		
Irregular heartbeat			Heartburn or indigestion not related to eating			Any other muscle/skeletal problems interfering with use of a respirator or other job duties		
High blood pressure								
Other heart problem or symptom								
Are you taking medication for any of the following problems?								
Heart trouble								
Blood pressure								
Seizures								
Vascular or heart problem								
Any breathing or lung problem								
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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:								

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.