WORKPLACE HEALTH SERVICE

A Service of Wyoming County Community Hospital

400 North Main Street Warsaw, NY 14569 (585) 786-8940, ext. 4549

MEDICAL QUESTIONNAIRE

Name:____

Social Security #:____________________ Date of Birth/Age:____________________

Complete Mailing Address:____

Street/PO Box City State Zip Code

Home Phone:____________ Work Phone:____________ Best time to reach you:______am/pm

Relative/Contact:____________________ Relation:____________________

Contact Address & Phone No.:____

Occupation: FIRE FIGHTER Job Duties: FIRE FIGHTER

Family Physician/Provider: ____________________ Address:____________________

PURPOSE

This information is requested to assure that any employment will not adversely affect the health or safety of you or your co-workers. The information, after evaluation, will become a part of your medical record, which is treated as confidential and will be released only as required by law. It is important, therefore, that your answers be complete and accurate.

AUTHORIZATION FOR TREATMENT

Knowing that I may require diagnostic testing, immunizations, and a medical exam by Workplace Health Service, a service of Wyoming County Community Hospital, I do hereby voluntarily consent to such medical treatment and a physical exam to determine medical clearance for the performance of my duties by the hospital medical staff as deemed necessary in their judgment.

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.

____

Applicant Signature Date

Permission to fax information to employer/company. [ ] Y [ ] N This authorization will expire six months from the date of signing.

Under Age 18:

You are required by law to have your parent or legal guardian co-sign for your examination as well. I agree that any abnormal findings in my medical exam may be released to my parent/guardian.

Signed:____

Parent/Guardian Signature:____

(authorizing treatment and release of medical information) Date

Would you like to talk to the health care professional who will review this questionnaire about your answers? Yes No

If yes, please make time to address your questions to the health professional with you today.

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Has your employer told you how to contact the health care professional who will review this questionnaire? Yes No

Do you **currently** take any medications (ex. heart or breathing trouble, blood pressure, seizures, any other)?
If yes, please list all:____

____

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:____

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:__________

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

Condition			Condition		
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

Symptom		
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** any of the following conditions? If yes, please indicate dates.

Seizures (fits)	Yes	No	Allergic reactions that interfere with your breathing	Yes	No
Diabetes (sugar disease)	Yes	No	Claustrophobia (fear of closed-in places):	Yes	No
Kidney problems	Yes	No	Trouble smelling odors	Yes	No
Liver problems	Yes	No			

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

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, 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:____

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

I hereby certify that all the information I have given is true, complete, and accurate to the best of my knowledge.

Signature:______________________________Date:___________ Examiners Initials:______

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