Holland Medi Center
335 N 120th, Holland, MI 49424
Phone: 616-392-5222
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Fire Fighter Medical History Form

Name: _____ Employer Name: _____ Date Of Exam: _____

Social Security Number: _____ Date Of Birth: _____ Job Title: _____

Home Address: _____ State: _____ Zip Code: _____

Gender: _____ Marital Status: _____

Past Medical History:	Yes	No	Explain & Give Date Of Occurrence
1. Are you currently taking any medication?	☐	☐	_____
2. Do you have any allergies, or are you allergic to any medications?	☐	☐	_____
3. Have you ever been advised to have or have had any surgeries?	☐	☐	_____
Review of Systems:			
4. Have you ever noticed any type of skin rash you feel was unusual?	☐	☐	_____
5. Are you exposed to any dust or chemicals at home?	☐	☐	_____
6. Have you ever had any trouble with your bones, tendons, muscles or joints?	☐	☐	_____
7. Have you had past or present back or neck problems?	☐	☐	_____
8. Have you had any fractures/broken bones?	☐	☐	_____
9. Have you had any back x-rays?	☐	☐	_____
10. Have you had any knee problems/operations?	☐	☐	_____
11. Have you had any hand, wrist or elbow problems?	☐	☐	_____
12. Have you had Carpal Tunnel Syndrome?	☐	☐	_____
13. Have you had Tendonitis?	☐	☐	_____
14. Have you ever had any problems with your liver, stomach, bowels, ulcers, hemorrhoids, or frequent upset stomach?	☐	☐	_____
15. Have you ever had a rupture or hernia?	☐	☐	_____
16. Have you ever had any nervous system disease or condition?	☐	☐	_____
17. Have you ever had fainting spells, blackouts, seizures, dizziness or headaches?	☐	☐	_____
18. Have you ever had any nervous condition (anxiety, depression)?	☐	☐	_____
19. Have you ever had any head injuries or concussion?	☐	☐	_____
20. Do you have any hearing defects?	☐	☐	_____
21. Did you have your appendix removed?	☐	☐	_____
22. Have you ever had any serious injuries, bad cuts or burns?	☐	☐	_____
23. Do you consider yourself in good health?	☐	☐	_____
24. Have you ever been in a program or treated in a clinic and/or hospital for drug and alcohol dependency?	☐	☐	_____
25. **If Female:** Give the date of your last menstrual period. _____ Are you or do you think that you are pregnant?	☐	☐	_____
26. Have you ever suffered from epilepsy (fits, seizures, convulsions)?	☐	☐	_____
27. Have you ever had Rheumatic fever?	☐	☐	_____
28. Have you ever had a Kidney disease?	☐	☐	_____
29. Have you ever had a Bladder disease?	☐	☐	_____
30. Have you ever had Diabetes?	☐	☐	_____
31. Have you ever had Jaundice?	☐	☐	_____
32. Do you have Hepatitis, TB, or HIV?	☐	☐	_____
33. Do you have Cirrhosis?	☐	☐	_____
34. Have you ever had Cancer?	☐	☐	_____
35. Have you ever had thyroid problems?	☐	☐	_____
36. Do you have arthritis or joint pain?	☐	☐	_____
37. Have you been in the hospital or under a physicians care anytime in the past year?	☐	☐	_____
38. Is there any change in your breathing since last year?	☐	☐	_____
If breathing has changed, do you know why?	☐	☐	_____

39. Do you wear glasses? ☐ ☐ _____
40. Do you have high blood pressure? ☐ ☐ _____
41. Have you ever had asthma, emphysema or a chronic cough? ☐ ☐ _____
42. Do you have any ear, nose, or throat problems? ☐ ☐ _____
43. Do you have any varicose veins or leg sores? ☐ ☐ _____
44. Do you have any physical defects/deformities? ☐ ☐ _____
45. Have you had significant weight loss or gain within the last year? ☐ ☐ _____
46. Have you had any recent injuries? ☐ ☐ _____

Occupational Medical History:

1. Have you ever had an Occupational disease or injury? ☐ ☐ _____
2. Have you ever had an exposure to chemical dust, fumes, vapors, chemical poisons, or excessive noise? ☐ ☐ _____
3. Have you ever worked in a coal mine, foundry, or with insulation? ☐ ☐ _____
4. Have you ever changed work, because of health reasons? ☐ ☐ _____
5. Have you ever lost any time from work in the past five (5) years due to any work related condition? ☐ ☐ _____
6. Have you ever been disqualified for duty or discharged from the armed services for medical reasons? ☐ ☐ _____
7. Please list all previous occupations and length of employment: _____

_____

Personal Social History:

1. Have you ever smoked? ☐ yes ☐ no If yes, how much / how long? _____
2. Do you regularly drink alcoholic beverages? ☐ yes ☐ no
   If yes, how many drinks, beers, or glasses of wine do you drink daily? ☐ <1 ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ >8
3. Do you have strenuous exercise for at least 30 minutes? ☐ daily ☐ 3 times a week ☐ 1 time a week ☐ rarely ☐ never
4. Do you feel frustrated, stressed, or uptight? ☐ daily ☐ 3 times a week ☐ 1 time a week ☐ rarely ☐ never
5. Do you eat greasy or fatty foods? ☐ daily ☐ 3 times a week ☐ 1 time a week ☐ rarely ☐ never

Family History:

Are Parents Still Living?	Yes	No	Age of death	Cause of death
Father	☐	☐		
Mother	☐	☐		

The name, address and phone number or my family Doctor is:

Name Of Practice: _____

Name Of Doctor: _____

Address: _____

Phone Number: _____

The Last Time I Saw My Doctor Was On _____

Please share my exam findings with my PCP ☐ yes ☐ no

I certify that I have answered truthfully questions regarding my health history and have not knowingly withheld any information concerning my health status either past or present. I also understand that this office will treat the information that I have provided in this questionnaire confidentially.

_____ _____

Patients Signature Date

Authorization Letter for the Release of Employee Medical Record Information to a Designated Representative

I, _____ (full name), hereby authorize _Holland Medicenter_ to release to _____ (individual or organization authorized to receive the medical information), the following medical information from my personal medical records:_____

_____

_____

(Describe generally the information desired to be released)

I give my permission for this medical information to be used for the following purpose:_____

_____

but I do not give permission for any other use or re-disclosure of this information.

Note:

Several extra lines are provided below so that you can place additional restrictions on this authorization letter if you want to. You may, however, leave these lines blank. On the other hand, you may want to (1) specify a particular expiration date for this letter (if less than one year); (2) describe medical information to be created in the future that you intend to be covered by this authorization letter; or (3) describe portions of the medical information in your records which you do not intend to be released as a result of this letter.):_____

_____

_____

_____

Full name of Employee or Legal Representative

_____ _____

Signature of Employee or Legal Representative Date of Signature

Holland Medicenter

335 N. 120th Ave • Holland, MI 49424
Phone: (616)392-5222 • Fax: (616) 392-8905

Medical History For Respirator Physical

Employer:_____ Date: _____

Employee:_____ DOB:_____ SS#: _____

Sex:_____ Height:_____ Weight:_____ Job Title: _____

Phone number:_____ Best Time You Can Be Reached At This Number: _____

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

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-facepiece type, powered air Purifying, supplied air, self-contained breathing apparatus).

Have you ever worn a respirator: ☐ Yes ☐ No

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

Questions 1 through 9 below must be answered by every employee who has been selected to use any type or respirator. Please circle "Yes" or "No".

Yes	NO	
____	____	1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?
		2. Have you ever had any of the following conditions?
____	____	Seizures (fits)
____	____	Diabetes (sugar diabetes)
____	____	Allergic reaction that interfered 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?
____	____	Asbestosis
____	____	Asthma
____	____	Chronic Bronchitis
____	____	Emphysema
____	____	Pneumonia
____	____	Tuberculosis
____	____	Silicosis
____	____	Pneumothorax (collapsed lung)
____	____	Lung Cancer
____	____	Broken Ribs
____	____	Any chest injuries or surgeries
____	____	Any other lung problem that you've been told about
		4. Do you currently have any of the following symptoms of pulmonary or lung illnesses?
____	____	Shortness of breath
____	____	Shortness of breath when walking fast on level ground or walking up a slight hill or incline.
____	____	Shortness of breath when walking with people at an ordinary pace on level ground.
____	____	Have to stop for breath when walking at an ordinary pace on level ground.
____	____	Shortness of breath when washing or dressing self.

Yes	No	
____	____	Shortness of breath that interferes with your job.
____	____	Coughing that produces phlegm (thick sputum).
____	____	Coughing that wakes you 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 symptoms that you think may be related to lung problems.

5. Have you ever had any of the following cardiovascular or heart problems?

____	____	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 you have been told about.

6. Have you ever had any of the following cardiovascular or heart symptoms?

____	____	Frequent pain or tightness in the 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 symptoms you think may be related to heart or circulation problems.

7. Do you currently take medication for the following problems?

____	____	Breathing or lung problems.
____	____	Heart trouble.
____	____	Blood pressure.
____	____	Seizures (fits).

8. If you have used a respirator, have you ever had any of the following problems? (If you have never used a respirator, check the following space and go to question 9)

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

9. Would you like to talk to the health care professional who will receive this questionnaire about your answers to the questionnaire?

Questions 10 to 15 must be answered by every employee who has been selected to use either a full-face respirator or a self contained breathing apparatus (SCBA). For employees who have been asked 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? Wear contact lenses. Wear glasses. Color blind. Any other eye or vision problems.
____	____	12. Have you ever had an injury to your ears, including a broken ear drum?
		13. Do you currently have any of the following hearing problems? Difficulty hearing. Wear a hearing aid. Any other hearing or ear problem.
____	____	14. Have you ever had a back injury?
		15, Do you currently have any of the following musculoskeletal problems? Weakness in any of your arms, hands, legs, or feet. Back pain. Difficulty fully moving your arms or legs. Pain or stiffness when you lean forward or backward at the waist. Difficulty bending at the knees. Difficulty squatting to the ground. Climbing a flight of stairs or a ladder carrying more than 25 lbs. Any other muscle or skeletal problem that interferes with using a respirator.
____	____	16. 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?
____	____	If "Yes", do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you are working under these circumstances?
____	____	17. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (Example: gases, fumes, or dust), or have you come into skin contact with hazardous chemicals?
		If "Yes", What? _____
		18. Have you ever worked with any of the materials, or under any of the conditions listed below? Asbestos. Silica (ex. in sandblasting). Tungsten/cobalt (ex. grinding or welding this material). Beryllium. Aluminum. Coal (ex. mining). Iron. Tin. Dusty environments. Any other hazardous exposure.
		If "Yes", describe these exposures: _____
____	____	19. Have you been in the military services?
____	____	If "Yes", were you exposed to biological or chemical agents (either in training or combat)?

20. List any previous occupations including second jobs and side businesses:

Yes	No	
____	____	21. Are you taking any other medications other than the ones mentioned above?

If "Yes", name the medication if you know them: _____

22. Will you be using any of the following items with your respirator?

____	____	HEPA Filters.
____	____	Canisters (for example, gas masks).
____	____	Cartridges.

23. How often are you expected to use the respirator(s) (circle "Yes" or "No" for all that apply to you.

____	____	Escape only (no rescue).
____	____	Emergency rescue only.
____	____	Less than 5 hours per week.
____	____	Less than 2 hours per day.
____	____	2 to 4 hours per day.
____	____	Over 4 hours per day.

24. During the period you are using the respirator(s), is your work effort:

____ ____ Light (less than 200 Kcal per hour)

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.

____ ____ Moderate (200 – 350 kcal per hour)

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; a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

____ ____ Heavy (above 350 kcal per hour)

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.).

____ ____ 25. Will you be wearing other protective clothing and/or equipment when using the respirator?

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

____ ____ 26. Will you be working under hot or humid conditions?

27. Describe any special or hazardous conditions you might encounter when you are using your respirator(s) (for example, confined spaces, life-threatening gases): _____

I certify that I have answered truthfully questions regarding my health history and have not knowingly withheld any information concerning my health status or exposure to chemicals either past or present.

_____ _____

EMPLOYEE SIGNATURE DATE

PFT Questionnaire

Name _____ **Today's Date** _____

Employer_____ **Birth Date**_____**SSN**_____

Race: ☐ African-American ☐ Caucasian ☐ Hispanic ☐ Other: _____

1. Smoking? ☐ Never ☐ Quit <1 yr ☐ Quit 1+ yrs ☐ Smoker
2. Have you experienced any new chest or breathing problems in the last month?..... ☐ YES ☐ NO
3. Are you in pain or do you feel ill in anyway?..... ☐ YES ☐ NO
4. Have you had any surgery or hospitalization in the past 4 weeks?..... ☐ YES ☐ NO
5. Have you eaten a large meal in the past hour?..... ☐ YES ☐ NO
6. Have you exercised vigorously in the past hour?..... ☐ YES ☐ NO
7. Do you currently have allergies that affect nose/sinus/breathing (hay fever)?..... ☐ YES ☐ NO
8. Do you have asthma?..... ☐ YES ☐ NO
9. Do you have a respiratory infection?..... ☐ YES ☐ NO
10. Have you had influenza or severe cold in the past 3 weeks?..... ☐ YES ☐ NO
11. Are you wearing any tight or restrictive clothing?..... ☐ YES ☐ NO
12. Have you used inhaler (bronchodialator) in the past hour?..... ☐ YES ☐ NO
13. Do you have a chronic cough (every day for the past 2months)?..... ☐ YES ☐ NO

Please remove anything you may have in your mouth including gum, candy, tongue ring, etc.

I herby certify that I have fully read the above questions and that my answers are true and correct.

Employee Signature _____ Date _____

Audio Questionnaire

Employee Information:

Name:_____ Today's Date: _____
Employer:_____ Social Security Number: _____
Date of Birth : Gender: Male ☐ Female ☐
How many hours since your last noise exposure? Less than 14 hrs. ☐ More than 14 hrs. ☐ Unknown☐
Do you use hearing protection? Yes ☐ No ☐ What type? Plugs ☐ Muffs ☐ Both ☐
How often do you use hearing protection? Always ☐ Not used ☐ Sometimes ☐

Preferred Testing Language:
English ☐ Spanish ☐ Vietnamese ☐ Cambodian ☐ Bosnian ☐ Korean ☐ Arabic ☐ French ☐ German ☐
Polish ☐ Italian ☐ Japanese ☐ Russian ☐ Hindi ☐ Tibetan ☐ Somali ☐ Tagalog ☐ Hmong ☐

Medical History **Please check your response**

1. Have you recently experienced pain in either ear? - - - - - - - - - - - - - ☐ Right ☐Left ☐Both ☐No
2. Have you recently experienced a draining ear? - - - - - - - - - - - - - - - ☐ Right ☐Left ☐Both ☐No
3. Have you recently experienced dizziness? - ☐ Yes ☐No
4. Have you recently experienced severe ringing in your ears? - - - - - - - - ☐ Right ☐Left ☐Both ☐No
5. Have you recently experienced sudden hearing loss? - - - - - - - - - - - - ☐ Right ☐Left ☐Both ☐No
6. Have you recently experienced fluctuating hearing loss? - - - - - - - - - - ☐ Right ☐Left ☐Both ☐No
7. Have you recently experienced ear fullness or discomfort? - - - - - - - - - ☐ Right ☐Left ☐Both ☐No
8. Have you recently had problems wearing hearing protection? - - - - - - - - - - - - - - - - ☐ Yes ☐No
9. Are you currently suffering from a cold or allergies? - ☐ Yes ☐No
10. Are you currently taking over-the-counter medications for cold or allergies? - - - - - - - ☐ Yes ☐ No

Complete below only if a follow-up test) **Please check your response**

1. Have you ever served in the military? - ☐ Yes ☐No
2. Have you ever been to a doctor for an ear-related problem? - - - - - - - ☐ Right ☐ Left ☐ Both ☐ No
3. Have you ever had a severe head injury? - ☐ Yes ☐No
4. Have you ever had measles? - ☐ Yes ☐No
5. Have you ever had mumps? - ☐ Yes ☐No
6. Have you ever had kidney disease? - ☐ Yes ☐No
7. Have you ever had scarlet fever? - ☐ Yes ☐No
8. Have you ever had meningitis? - ☐ Yes ☐No
9. Do you have diabetes? - ☐ Yes ☐No
10. Do you have high blood pressure? - ☐ Yes ☐No
11. Do you have an existing hearing problem? - ☐ Yes ☐No
12. Do you shoot guns or hunt? - ☐ Yes ☐No
13. Do you wear a hearing aid? - ☐ Right ☐ Left ☐ Both ☐ No
14. Do you participate in loud activities (music, motorcycles, power tools)? - - - - - - - - - ☐ Yes ☐No
15. Does any of your immediate family have hearing problems? - - - - - - - - - - - - - - - - - ☐ Yes ☐No
16. Have you ever had ear surgery? - ☐ Right ☐ Left ☐ Both ☐ No
17. Do you have frequent ear infections? - ☐ Right ☐ Left ☐ Both ☐ No

Employee Signature: _____

EXAMINER ONLY:
Does employee have visible wax or object in ear? **Right ear:** Yes ☐ No ☐ **Left ear:** Yes ☐ No ☐

Examiner Name: _____ **Date:** _____