Health and Safety Specialists in Medicine, P.C.

236 Crystal Run Rd Ste 2, Middletown, NY 10941
(T) 877.914.3473 • (F) 877.301.8530 •
firephysicalsny@gmail.com

Fire Department

Firefighter Name

Date

PLEASE PRINT

HEALTH & SAFETY SPECIALISTS is pleased to offer you medical examinations.
We hope that your exam is comfortable and provides you with the confidence of good health.

If you're having blood work, please fill out an envelope so we may mail your results directly to your home.

You are also able to retrieve your results directly from Quest Diagnostics.
Please go to MYQUEST.COM to register on their patient portal.

OSHA QUESTIONNAIRE:

- Vision
- Hearing
- Lung Function
- EKG
- Blood Pressure
- Weight/BMI

VACCINES:

- Initial Hep B Series (3 shots)
- Hep B Booster
- Influenza (Flu)

LAB BLOOD WORK:

- Comprehensive Chemistry, CBC, and Cholesterol
- Prostate (age >40)

PROCEDURES / TESTING:

- PPD/TB
- Urinalysis
- Urine Drug Screen
- FIT Test
- Firefighter Stress Test
- CDL/DOT
- Sonograms

MEDICAL EXAM:

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OSHA Respirator Medical Evaluation Questionnaire

Standard Title: Respiratory Protection
Subpart Number: I
Subpart Title: Personal Protective Equipment
Produced by USDOL OSHA-OCIS
Standard Number: 1910.134 App C

Can you read: ☐ Yes ☐ No

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:
2. Your name:
3. Your age (to nearest year):
4. Sex: ☐ Male ☐ Female
5. Your height: ☐ ft. ☐ in.
6. Your weight: ☐ lb.
7. Your job title:
8. A phone number where you can be reached by the physician who reviews this questionnaire:
9. The best time to call you at this number:
10. Has your employer told you how to contact the health care professional who will review this questionnaire:
    ☐ Yes ☐ No
11. 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-face piece type, powered-air purifying, supplied air, self-contained breathing apparatus).
12. Have you worn a respirator previously (circle one): ☐ Yes ☐ No
    If "yes", what type(s):

Firefighter Name:

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee. (Please mark "Yes" or "No")

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?

Yes No

2. Have you ever had any of the following conditions:

Yes No a. Seizures (fits)
Yes No b. Diabetes (sugar disease)
Yes No c. Allergic reactions that interfere with your breathing
Yes No d. Claustrophobia (fear of closed-in places)
Yes No e. Trouble smelling odors

3. Have you ever had any of the following pulmonary or lung problems:

Yes No a. Asbestosis
Yes No b. Asthma
Yes No c. Chronic bronchitis
Yes No d. Emphysema
Yes No e. Pneumonia
Yes No f. Tuberculosis
Yes No g. Silicosis
Yes No h. Pneumothorax (collapsed lung)
Yes No i. Lung cancer
Yes No j. Broken ribs
Yes No k. Any chest injuries or surgeries
Yes No l. Any other lung problem that you've been told about

4. Do you currently have any of the following symptoms of pulmonary or lung illness:

Yes No a. Shortness of breath
Yes No b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
Yes No c. Shortness of breath when walking with other people at an ordinary pace on level ground
Yes No d. Have to stop for breath when walking at your own pace on level ground
Yes No e. Shortness of breath when washing or dressing yourself
Yes No f. Shortness of breath that interferes with your job
Yes No g. Coughing that produces phlegm (thick sputum)
Yes No h: Coughing that wakes you early in the morning
Yes No i: Coughing that occurs mostly when you are lying down
Yes No j. Coughing up blood in the last month
Yes No k. Wheezing
Yes No l. Wheezing that interferes with your job
Yes No m: Chest pain when you breathe deeply
Yes No n: 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:

Yes No a. Heart attack
Yes No b. Stroke
Yes No c. Angina
Yes No d: Heart failure

Firefighter Name:

Yes No e. Swelling in your legs or feet (not caused by walking)
Yes No f: Heart arrhythmia (heart beating irregularly)
Yes No g. High blood pressure
Yes No h. Any other heart problem that you've been told about

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

Yes No a. Frequent pain or tightness in your chest
Yes No b. Pain or tightness in your chest during physical activity
Yes No c. Pain or tightness in your chest that interferes with your job
Yes No d. In the past two years, have you noticed your heart skipping or missing a beat
Yes No e. Heartburn or indigestion that is not related to eating
Yes No f. Any other symptoms that you think may be related to heart or circulation problems

7. Do you currently take medication for any of the following problems:

Yes No a. Breathing or lung problems
Yes No b. Heart trouble
Yes No c. Blood pressure
Yes No d. Seizures (fits)

8. If you've used a respirator, have you ever had any of the following problems:

Yes No a. Eye irritation
Yes No b. Skin allergies or rashes
Yes No c. Anxiety
Yes No d. General weakness or fatigue
Yes No e. Any other problem that interferes with your use of a respirator

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

Yes No

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:

Yes No a. Wear contact lenses
Yes No b. Wear glasses
Yes No c. Color blind
Yes No d. Any other eye or vision problem

12. Have you ever had an injury to your ears, including a broken ear drum?

Yes No

13. Do you currently have any of the following hearing problems?

Yes No a. Difficulty hearing
Yes No b. Wearing a hearing aid
Yes No c. Any other hearing or ear problem

Firefighter Name:

14. Have you ever had a back injury:?

Yes No

15. Do you currently have any of the following musculoskeletal problems:

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

Part B: Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals:

Yes No If "yes" name the chemicals if you know them:

2. Have you ever worked with any of the materials, or under any of the conditions listed below:

Yes	No	a. Asbestos
Yes	No	b. Silia (e.g., in sandblasting)
Yes	No	c. Tungsten/cobalt (e.g., grinding or welding this material)
Yes	No	d. Beryllium
Yes	No	e. Aluminum
Yes	No	f. Coal (for example, mining)
Yes	No	g. Iron
Yes	No	h. Tin
Yes	No	i. Dusty environments
Yes	No	j. Any other hazardous exposures? If "yes", describe these exposures:

3. Have you ever served in the military?

Yes No If "yes", were you exposed to biological or chemical agents (either in training or combat):

Yes No

4. Have you ever worked on a HAZMAT team?

Yes No

5. Are you taking any other medications for any reason (including over-the-counter medications)?

Yes No If "yes" name the medications if you know them:

6. Have you ever received vaccination for Hepatitis B?

Yes No If "yes", when was it last administered?

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Follow Up & Physical Form

Name DOB

Address Phone

Email

PHYSICIAN NOTES:

PMHx

PSHx

Meds Yes No

Allergies Yes No Smoker Yes No

Back Pain Yes No Pulse OX Eyes R B L

Vitals BP HR HT WT BMI

Skin HEENT Neck

Thyroid Carotids

Lungs Heart Pulses

ABD Hernia Yes No Extremeties

Joints Clubbing/Cyanosis Yes No

Neurologic Back

Additional Notes

IMPRESSION:

Normal Exam Deferred

Problems Recommend

CLASS A FIREFIGHTER: Medically qualified for INTERIOR duties

CLASS B FIREFIGHTER: Medically qualified for EXTERIOR duties

CLASS C FIREFIGHTER: NOT qualified for FIREGROUND duties Fire/Police Duty Yes No

The following restrictions apply Office/Admin. Yes No

Unable to lift more than lbs.

Signed

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Fire District: Date:

Name:

DOB:

- **CLASS A FIREFIGHTER:** Medically qualified for INTERIOR duties
- **CLASS B FIREFIGHTER:** Medically qualified for EXTERIOR duties
- **CLASS C FIREFIGHTER:** NOT qualified for FIREGROUND duties

Fire Police Duty Yes No

Office/Admin. Yes No

The following restrictions apply:

Unable to lift more than lbs.

Signed

Raymond S Basri, MD