Holland Medicenter
335 North 120th Ave
Holland, MI 49424
Phone: (616) 392-5222
Fax: (616) 392-3653

Lead Exam Medical History

Employee Name:_____ DOB: _____ Age:_____ SSN:_____

Employer Name:_____ Yrs with Company:____Date of Service:_____

1. Are you currently under the care of a physician? ☐ YES ☐ NO If Yes, please state physician name:_____
2. Have you had any serious illness(es), operations, or been hospitalized? ☐ YES ☐ NO
   If Yes, please describe:_____
   _____
3. Please list all medical conditions for which you have seen a doctor: _____
   _____
4. List any Medications you are currently taking (include dose/frequency)_____
   _____
5. List any Allergies to Medications you have:_____
6. Do you use alcohol? ☐ YES ☐ NO If yes, how much? _____ drinks/week
7. Do you use tobacco? ☐ YES ☐ NO If yes, how much? _____ packs/week How long? _____ years
8. Please list any hobbies that could pre-dispose you to lead exposure (riflery, etc.).____
9. Have you ever had an exposure to lead that you know of (Lead paint, etc.)? ☐ YES ☐ NO When?_____
10. If female, are you pregnant or do you feel there is a possibility that you might be pregnant? ☐ YES ☐ NO

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK AND EXPLAIN BELOW.

☐ 11. Unexplained weight loss
☐ 12. Lack of energy
☐ 13. Decreased appetite
☐ 14. Headaches
☐ 15. Blurred vision/difficulty with vision
☐ 16. Difficulty with hearing
☐ 17. Ringing in the ears
☐ 18. Dark spots on your gums/cheeks
☐ 19. Metallic taste in mouth
☐ 20. Shortness of breath
☐ 21. cough
☐ 22. Chest pain
☐ 23. Irregular heart beats
☐ 24. Short of breath when lying down
☐ 25. Upset stomach/excessive vomitting
☐ 26. Heartburn / indigestion
☐ 27. Abdominal (stomach) pain
☐ 28. Constipation
☐ 29. Diarrhea
☐ 30. Irritability
☐ 31. Difficulty sleeping
☐ 32. Loss of memory, confusion, hallucinations
☐ 33. Dizziness, incoordination
☐ 34. Decreased strength in arms or legs
☐ 35. Difficulty with climbing stairs
☐ 36. Pale (white) skin
☐ 37. Abnormal blood loss/bruising
☐ 38. Blood in stool/black, tarry stools
☐ 39. Unable to make babies
☐ 40. Difficulty with impotence
☐ 41. Decreased sex drive
☐ 42. Abnormal menstrual periods
☐ 43. History of miscarriage/stillbirths
☐ 44. Had children with birth defects
☐ 45. Excessive muscle or joint pain

_____
_____
_____

I certify I have read and understand the above. I hereby certify that my answers are true and correct to the best of my knowledge. I understand that this questionnaire is solely for my employer's use and is not designed to discover, diagnose, or treat any illness or condition that I might have. I understand I should consult my family physician for such examinations. I hereby authorize the release of all pertinent information to the above employer and/or insurers.

_____ _____
Signature Date

Health Care Provider's comments/initials_____
_____

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 _____