american family care
URGENT CARE
1171 East Mian Street, Torrington, CT 06790 Phone 860-866-4321

Date: Name: ss#

Street address: City/State: Zip code:

Phone: Company: ☐Male ☐Female Date of Birth

Medical History, past and present (Please check all that apply)

☐Recent weight gain or loss
☐Difficulty sleeping/ Sleep Apnea

Head, eyes, Ears, Throat
☐Hearing Loss
☐Color Blindness
Numbness/Tingling
☐Dental Problems
☐Glasses/ Contacts
☐Head injury
☐Headaches/ dizziness/fainting

Skin
☐Skin sensitivity to chemicals
bone
☐Eczema
☐Psoriasis
☐Others

Genitourinary
☐Kidney disease/ stone
☐Reproductive/ Infertility
☐Pregnancy

☐Tumors/ Cancer

☐Motor Vehicle Accidents
☐Other medical issues:_____

Cardiovascular (Heart)
☐Hypertension
☐High Cholesterol
☐Heat attack/ chest pain
☐Irregular heart rate/ Arrhythmia
☐Heart Murmur

Pulmonary (Lungs)
☐Asthma/ chronic bronchitis
☐Shortness of breath with exercise
☐Chronic cough/ wheezing
☐Tuberculosis

Gastrointestional (stomach)

☐Ulcer/ reflux Disease
☐Bowel problems
☐Inflammatory Bowel disease
☐Hepatitis
☐Hernia

Emotional
☐Anxiety
☐Psychiatric treatment/ medication
☐Worry/Depression/Nervousness
☐Surgical History/ operations

Neurological
☐Seizures/Epilepsy
☐stroke
☐Multiple Sclerosis
☐Balance unsteady

Musculoskeletal
☐Back/Neck Problems
☐Should, Elbow, Wrist,
Hand problems
☐Hip, knee, ankle, foot
☐Fractures, broken
☐ Arthritis, Tendonitis
Bursitis
☐carpal tunnel syndrome

Endocrine
☐Diabetes
☐Thyroid disease

Hemtologic
☐Bleeding disorder
☐Anemia
☐Transfusion

☐Prior Hospitalizations

Please explain all checked answers:

Current Medications: ☐None

Allergies: _____

Immunizations: Hep B status ☐ immune ☐ Not Immune ☐Unknown

Substance abuse:

Have you ever been treated for illegal drug use? ☐Yes ☐ No Date_____

Have you ever been treated for alcohol use? ☐Yes ☐ No Date_____

Social History:

How many drinks (beer, wine, hard liquor) do you have per week? _____

Do you or have you in the past smoked or used tobacco? ☐Yes ☐No ☐Former

Including chewing ☐ Quit date_____

What percentage of the time do you wear your seatbelt? ☐Always ☐Never ☐Sometimes

Do you exercise regularly? ☐ Yes ☐No number of times per week_____ Play sports? _____

Have you served in the Military? ☐Yes ☐No Type of discharge _____ ☐ with a disability?

Occupational History: Have you ever

Filed a worker's comp claim or received benefits as a result of a work-related injury or illness?

☐Yes ☐ No Explain_____

Needed to change jobs or have to modify a job due to a health problem? ☐ Yes ☐No

Explain_____

Experienced overexposure to or ill effects from chemical exposure? ☐ Yes ☐No

Explain_____

Received a disability settlement or a permanent impairment rating? ☐ Yes ☐ No

Do you work another job? ☐Yes ☐No Where _____

Besides Volunteer Firefighting, what type of work do you do? _____

Do you have any hobbies that include: (circle any that apply) use of paints, solvents or glue loud noises weight lifting use air-driven power tools motorcycle or dirt bike riding Car racing ATV or quad riding

Have you ever needed to wear personal protective equipment? Check all that apply

☐Respirator ☐Hearing protection ☐Safety glasses ☐Protective clothing

Did you have any difficulty wearing this equipment? ☐Yes ☐ No

Have you received medical examinations as part of your prior job? ☐ Yes ☐No

I verify that the above is true and correct to the best to my knowledge

Patient Signature: _____ Date _____

Provider Signature: _____ Date _____

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

TO THE EMPLOYER

Answers to questions in Section 1, and to question 9 in section 2 of part A, do not require a medical examination. However, it does require that a Physician or Licensed Health Care Professional (PLHCP) review this questionnaire and answer any questions you may have concerning the questions asked in this questionnaire.

TO THE EMPLOYEE

Can you read? (Circle one) Yes No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

TO THE PHYSICIAN and OTHER LICENSED HEALTH CARE PROFESSIONAL (PLHCP)

Review Part A Sections 1 and 2. When an employee answers YES to any of the questions in Section 2 and the questionnaire is not administered in conjunction with a physical examination, the employee needs to be considered for a follow-up physical examination with particular emphasis on those areas in which the employee answered YES. When an employee answers YES to any of the questions in Section 2 and this questionnaire is completed in conjunction with a physical examination, the physician will place particular emphasis upon those areas to which the employee answered YES.

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: _____ Your Social Security # _____/ _____/ _____
3. Your age (to nearest year): _____
4. Sex (circle one): Male / Female
5. Your height: _____ ft. _____ In.
6. Your weight: _____ lbs.
7. Your job title:_____
8. A phone number where you can be reached by the health care professional who will review this questionnaire (include area code): _____
9. The best time to phone you at this number is: am/ pm.
10. Has your employer told you how to contact the health care professional who will review this questionnaire? (circle one): 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 (circle one): Yes No

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

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Part A. Section 2. (Mandatory)

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. (Please circle 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?		
	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	Yes	No
3.	Have you ever had any of the following pulmonary or lung problems?		
	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	Yes	No
4.	Do you currently have any of the following symptoms of pulmonary or lung illness?		
	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	Yes	No
5.	Have you ever had any of the following cardiovascular or heart problems?		
	a. Heart attack	Yes	No
	b. Stroke	Yes	No
	c. Angina	Yes	No
	d. Heart failure	Yes	No
	e. Swelling in your legs or feet (not caused by walking)	Yes	No

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

f.	Heart arrhythmia (irregular heartbeat)	Yes	No
g.	High blood pressure	Yes	No
h.	Any other heart problem that you've been told about	Yes	No

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

a.	Frequent pain or tightness in your chest	Yes	No
b.	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	Yes	No

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

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

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

(If you've never used a respirator, check the following space and go to question 9._____.)

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	Yes	No

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

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected 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?

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

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?

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

14. Have you ever had a back injury? Yes No

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

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

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 you head up or down	Yes	No
f.	Difficulty fully moving you head side to side	Yes	No
g.	Difficulty bending at your knees	Yes	No
h.	Difficulty squatting to the ground	Yes	No
i.	Difficulty climbing stairs or a ladder carrying more than 25 pounds	Yes	No
j.	Any other muscle or skeletal problem that interferes with using a respirator	Yes	No

Employee Name: _____

Signature: _____

Date: _____

To Professional Licensed Health Care Professionals - PLHCP (MD, DO, PA and APRN)
Please select one of the options

- ☐ I have reviewed above OSHA Respirator Medical Evaluation Questionnaire with the employee and physical examination of employee is recommended.
- ☐ I have reviewed above OSHA Respirator Medical Evaluation Questionnaire with the employee and physical examination of employee is not recommended.
- ☐ I have reviewed above OSHA Respirator Medical Evaluation Questionnaire without the employee and physical examination of employee is recommended.
- ☐ I have reviewed above OSHA Respirator Medical Evaluation Questionnaire without the employee and physical examination of employee is not recommended.

PLCP Name: _____

Signature: _____

Date: _____

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Part B. (Discretionary)

Any of the following questions and other questions may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. 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? Yes No

   If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest or other symptoms when you're working under these conditions? Yes No

2. At work or home, have you ever been exposed to hazardous solvents or hazardous airborne chemicals (e.g., gases, fumes or dust) or come into skin contact with hazardous chemicals? Yes No

   If "yes," name the chemicals if you know them: _____

   _____

   _____

   _____

3. Have you ever worked with any of the materials or under any of the conditions listed below?

   a. Asbestos Yes No
   b. Silica (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 (e.g., mining) Yes No
   g. Iron Yes No
   h. Tin Yes No
   i. Dusty environments Yes No
   j. Any other hazardous exposures Yes No

   If "yes," describe these incidents of exposures: _____

   _____

   _____

   _____

4. List any second jobs or side businesses you have: _____

   _____

5. List your previous occupations: _____

   _____

6. List your current and previous hobbies: _____

   _____

7. Have you been in the military services? Yes No

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

8. Have you ever worked on hazardous material team? Yes No

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

9. Other than medications for breathing and lung problems, heart trouble, blood pressure and seizures mentioned earlier in this questionnaire, 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: _____

   _____

   _____

10. Will you be using any of the following items with your respirator(s)?

    a. High-efficiency purifying air filters Yes No
    b. Canisters (e.g., gas masks) Yes No
    c. Cartridges Yes No

11. How often are you expected to use the respirator(s)? Circle "yes" or "no" for all answers that apply to you.

    a. Escape only (no rescue) Yes No
    b. Emergency rescue only Yes No
    c. Less than five hours per week Yes No d. Less than two hours per day Yes No
    d. Two to four hours per day Yes No
    e. More than four hours per day Yes No

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

    a. Light (less than 200 kcal per hour)? Yes No
       If "yes," how long does this period last during the average shift? _____ hours _____ minutes.
       Examples of a light work effort are sitting while writing, typing, drafting or performing light assembly work and standing while operating a drill press (1to 3 pounds) or controlling machines.

    b. Moderate (200 to 350 kcal per hour): Yes No
       If "yes" how long does this period last during the average shift? _____ hours _____ minutes.
       Examples of a 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 pounds) at truck level; walking on a level surface about 2 mph or down a 5 degree grade about 3 mph; and pushing a wheelbarrow with a heavy load (about 100 pounds) on a level surface.

    c. Heavy (above 250 kcal per hour): Yes No
       If "yes" how long does this period last during the average shift? _____hours _____minutes.
       Examples of heavy work are lifting a heavy load (about 50 pounds) from 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; and climbing stairs with a heavy load (about 50 pounds).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator? Yes No

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

    _____

    _____

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

14. Will you be working under hot conditions (temperature exceeding 77 F)? Yes No

15. Will you be working under humid conditions? Yes No

16. Describe the work you'll be doing while you're using your respirator(s): _____

_____

_____

_____

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (e.g., confined spaces, life-threatening gases): _____

_____

_____

_____

18. Provide the following information, if you know it, for each toxic substance you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the second toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the third toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

The name of any other toxic substances you will be exposed to while using your respirator: _____

_____

_____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (e.g., rescue, security): _____

_____

_____

_____

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Appendix D to 29 CFR 1910.134.
Information for Employees Using Respirators When Not Required Under the Standard

Respirators are an effective method of protection against designated hazards when properly selected and worn. Respirator use is encouraged, even when exposures are below the exposure limit, to provide an additional level of comfort and protection for workers. However, if a respirator is used improperly or not kept clean, the respirator itself can become a hazard to the worker. Sometimes, workers may wear respirators to avoid exposures to hazards even if the amount of hazardous substance does not exceed the limits set by OSHA standards. If your employer provides respirators for your voluntary use or if you provide your own respirator, you need to take certain precautions to be sure the respirator itself does not present a hazard.

1. Read and heed all instructions provided by the manufacturer on use, maintenance, cleaning and care, and warnings regarding the respirator's limitations.
2. Choose respirators certified for use to protect against the contaminant of concern. The National Institute for Occupational Safety and Health (NIOSH) of the U.S. Department of Health and Human Services, certifies respirators. A label or statement of certification should appear on the respirator or respirator packaging. It will tell you what the respirator is designed for and how much it will protect you.
3. Do not wear your respirator into atmospheres containing contaminants for which your respirator is not designed to protect against. For example, a respirator designed to filter dust particles will not protect you against gases, vapors, or very small solid particles of fumes or smoke.
4. Keep track of your respirator so you do not mistakenly use someone else's respirator.

Employee Name: _____

Signature: _____

Date: _____

Medical Status Determination for Respirator use in accordance with 29CRF 1910.134 Respiratory Protection Standard

Name: _____ Date of Exam: _____
Employer Contact: _____
Employer: _____
Address: _____

A Medical Surveillance review was conducted consisting of the following:
_____ Review of mandated medical questionnaire completed by employee
_____ Physical Examination
_____ Additional services: _____Spirometry; _____Chest X-ray; _____EKG; _____Audio; _____Labs; _____Fit test

Based on this review and additional information regarding the Respiratory Protection Program and respirator use supplied by the employer, I conclude:
_____ There are no limitations on respirator use for this individual once they have been properly fitted and trained.
_____ This individual has vision impairment. Corrective lenses may be required if they are assigned a full face respirator.
_____ Must shave for proper fit of negative pressure respirator.
_____ Individual advised that cigarettes increases the risk of lung diseases and cancer and may compound the risks of exposure to asbestos, arsenic, cadmium, and other toxic substances. Advised smoking cessation.
_____ A Baseline respiratory examination is recommended to clarify issues from review of the mandated medical questionnaire. Please call the office to schedule an appointment.

_____ This employee is not medically suitable to use respiratory protective equipment at this time.
_____ We recommend re-evaluation for respirator use as indicated below or as otherwise indicated under 29 CFR 1910.134 Respiratory Standard
- _____ 1 year (Commonly for follow up of a baseline condition, Hazmat or emergency responder team member, wearers of SCBA, IDLH atmosphere, age over 45)
- _____ 2 years (Commonly for ages 35-45)
- _____ 3 years (Commonly for individual's age less than 35 years)

_____ Individual is advised of a medical condition that may merit further evaluation or motoring.
_____ Individual referred to personal physician for non-occupational medical condition.
Comments:
_____
_____
_____

_____ Preliminary Report

_____ Final Report

_____ _____
Physician/Provider Date

AFC Center: _____

(AFC Clinic Stamp)

The above individual has been informed of the results of this exam and the potential health effects of the pertinent exposure(s) and has been supplied with a copy of these written opinions. The entire examination will be maintained by us as a confidential medical record in accordance with regulatory statues.

HEPATITIS B VACCINE ACCEPTANCE/DECLINATION FORM

ACCEPTANCE:

I understand that due to my occupational exposure to blood or other potentially infectious materials that I may be at risk of being infected by bloodborne pathogens, including Human Immunodeficiency Virus (HIV) and Hepatitis B Virus (HBV). This is to certify that I have been informed about the symptoms and the hazards associated with these viruses, as well as the modes of transmission of bloodborne pathogens. I have been given the opportunity to be vaccinated with Hepatitis B vaccine. In addition, I have re ceived information regarding the Hepatitis B (HBV) vaccine. Based on the training I received, I am making an informed decision to accept the Hepatitis B (HBV) vaccine.

DECLINATION:

I understand that due to my occupational exposure to blood or other poten tially infectious materials that I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can do so at any time.

CHECK ONE:

☐ I ACCEPT Hepatitis B vaccine inoculation: OR

☐ I DECLINE Hepatitis B vaccine inoculation.

☐ Vaccinated/Immune for Hepatitis B

Employee's Name:_____

Employee's Signature:_____ Date:_____