Carolina Family Health Centers, Inc.

Carolina Family Dental Center • Freedom Hill Community Health Center • Harvest Family Health Center • Wilson Community Health Center

Medical Screening Questionnaire

Employee Name (printed) ____

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 do not require a medical examination.

To the employee: Can you read (circle one): Yes No

Section 1. PERSONAL INFORMATION (MANDATORY)

Date: _________ Name:____
(first) (middle) (last)

DOB: _____ Sex (circle one): Male Female Height: ____ ft. ___in. Weight: _____lbs.

Job Title: ______________________________ Department: ___________________________

A phone number where you can be reached by the health care professional who reviews this questionnaire:
_______________ The best time to phone you at this number: _____________

Has your employer told you how to contact the healthcare professional who will review this questionnaire? (circle one): Yes No

Check the type of respirator you will use (you can check more than one category)

a. _______N, R, or P disposable respirator you will use (you can check more than one category)
b. _______Other type (for example, half- or full-facepiece type, powered-air purifying, supplies-air, self-contained breathing apparatus)

Have you worn a respirator in the last year? (circle one):
Yes No
If "yes," what type(s): ____

Section 2 (MANDATORY)

The questions below must be answered by every employee who has been selected to use any type of respirator. Please circle "yes" or "no" to the following.

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) not associated with a cold: 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
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:	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. 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
e. Other ____		

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 healthcare professional who will review this questionnaire?
about your answers to this questionnaire: Yes No

Employee Name (printed): ____

Employee Signature: ____ Date: ________________________