Bernalillo County Fire Department
Medical and Occupational Questionnaire

Date_____
Time_____

Can you read (check 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.

This physical exam is intended to verify your physical capability to perform the job for which you are being hired. It is not intended to take the place of exams given by your personal physician.

Name: _____ Date: _____
(Last) (First) (Initial)

Social Security Number:_____-_____-_____ Date of Birth:_____ Age:_____

A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____ The best time to call this number: _____

Has your employer told you how to contact the health care professional who will review this questionnaire (check one):

☐ Yes ☐ No

Reason For Exam: Post Offer Exam ☐ Annual ☐ Other ☐ OSHA ☐

Currently who is your primary health care physician? Name: _____

Check the type of respirator you will use (you can check more than one category):
☐ N ☐ R ☐ P disposable respirator (filter-mask, non- cartridge type only).
☐ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Have you worn a respirator (circle one): ☐ Yes ☐ No If "yes," what type(s): _____

	Yes	No
Have you ever been injured on the job in any way?	☐	☐
Have you ever gotten sick in any way from something you worked with on the job?	☐	☐
Has your work ever caused trouble with your joints (wrists, hands, knees, etc.), your back, or your skin?	☐	☐
Do you have any hobbies in which you use chemicals, metals, loud machines or tools or potentially hazardous substances?	☐	☐
Have you ever had to terminate any job for health reason?	☐	☐
Have you ever had to transfer from one job to another or change job duties for health reasons?	☐	☐
Have you ever been refused any job for health reasons?	☐	☐
Has a doctor ever placed restrictions on the kind of work you should do?	☐	☐
Has a doctor ever placed restrictions on you lifting, bending, twisting, walking, standing, sitting or using your hands or arms?	☐	☐
Have you ever had a back injury or experienced back pain or back strain?	☐	☐
Have you ever made a legal claim for any injury?	☐	☐
Do you have any medical limitations which preclude you from performing the job which you are applying for,	☐	☐
Have you ever received Worker's Compensation Benefits? If yes, explain below.	☐	☐

_____

_____

_____

_____

Name:_____ Social Security Number:_____-_____-_____ Page
(Last) (First) (Initial)

HEALTH MAINTENANCE RECORD

Are you now under the care of a physician for health problem? ☐ Yes No ☐
if Yes, what is the problem(s)? _____

When did you last have any of the following?

	Date	Results Where	(if applicable)
Physical Exam			
Eye Exam			
Chest X-Ray			
Back X-Ray			
Other X-Rays			
(Type)			
Tetanus Shot			
Skin Test for TB			
Hepatitis Vaccine			
Rubella Vaccine			

Have you ever received instruction in back care and lifting techniques? ☐ Yes Date _____ No ☐

Females:

Pap Smear			
Breast Exam			

Have you ever been instructed in breast self -examination? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Have you ever been hospitalized?	☐ Yes	☐ No
Do you have any physical disabilities?	☐ Yes	☐ No
Were you born with any physical defects?	☐ Yes	☐ No
Have you ever had surgery?	☐ Yes	☐ No
Have you ever broken a bone?	☐ Yes	☐ No

If YES to any of the above, list the specific details including dates and names of treating physician.

Name:_____ Social Security Number:_____-_____-_____ Page
(Last) (First) (Initial)

FAMILY HISTORY

Have any of your parents, brothers and/or sisters ever had:

High blood pressure ☐ Heart problems ☐ Stroke ☐ Diabetes ☐ Cancer ☐ Bleeding disorder ☐

Mental disorder ☐ Alcoholism ☐

MEDICATIONS

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

Breathing or lung problems	☐ Yes	☐ No
Heart trouble	☐ Yes	☐ No
Blood pressure	☐ Yes	☐ No
Seizures (fits)	☐ Yes	☐ No

List any medicines you are taking (including over-the-counter medications)::

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES

List any allergies you have to drugs, foods, pollen, smoke, etc.

_____ _____ _____

_____ _____ _____

REVIEW OF SYSTEMS

Indicate whether or not you have a health problem or have had in the past a significant problem that falls under any of the numbered categories listed below. If your answer is "yes" check the phrases under each category that best describe the problem. Explain in detail at the end of the section.

Problem with overall fitness and feeling of well-being? ☐ Yes ☐ No (If yes check all that apply)

- ☐ Unexplained Fever
- ☐ Unexplained Weight Loss/Gain
- ☐ Unusual Sweating
- ☐ Weakness
- ☐ Fatigue

Problem with Skin? ☐ Yes ☐ No (If yes check all that apply)

- ☐ Recurrent or Persistent Rash
- ☐ Unexplained Itching
- ☐ Eczema
- ☐ Allergic Skin Rash
- ☐ Acne
- ☐ Psoriasis
- ☐ Dry Cracked Skin
- ☐ Yellow color

Problem with Blood or Bleeding? ☐ Yes ☐ No (If yes check all that apply)

- ☐ Anemia (Low Blood count)
- ☐ Nose Bleeds
- ☐ Bruising
- ☐ Bleeding Trait

Problems with Diabetes? ☐ Yes ☐ No

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Problem with Muscles, Joints, Back? ☐ Yes ☐ No (If yes check all that apply)

- ☐ Back pain
- ☐ Painful, Stiff or Swollen Joints
- ☐ Arthritis
- ☐ Gout
- ☐ Back Injury
- ☐ Difficulty fully moving your arms and legs
- ☐ Difficulty fully moving your head up or down
- ☐ Difficulty fully moving your head side to side
- ☐ Difficulty bending at your knees
- ☐ Difficulty squatting to the ground
- ☐ Sciatica
- ☐ Sore Muscles
- ☐ Disease of muscle or bone
- ☐ Climbing a flight of stairs or a ladder carrying more than 25 lbs
- ☐ Weakness in any of your arms, hands, legs, or feet
- ☐ Any other muscle or skeletal problem that interferes with using a respirator
- ☐ Pain or stiffness when you lean forward or backward at the waist

Problem with Eyes or Vision? ☐ Yes ☐ No (If yes check all that apply)

- ☐ Wear Glasses/Contacts
- ☐ Loss of vision in either eye
- ☐ Lazy Eye
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Yellow eyes
- ☐ Color blind
- ☐ Any other eye or vision problem

Problem with the Ears or Hearing? ☐ Yes ☐ No (If yes check all that apply)

- ☐ Wear a hearing aid
- ☐ Ringing or Buzzing in the Ears
- ☐ Loss of Hearing
- ☐ Ear Infection
- ☐ Any other hearing or ear problem
- ☐ Have you ever had an injury to your ears, including a broken ear drum

Nose and Throat Problems? ☐ Yes ☐ No (If yes check all that apply)

- ☐ Sinus Trouble
- ☐ Hay Fever
- ☐ Recurrent Sore Throats

Have you ever had any of the following pulmonary or lung problems? ☐ Yes ☐ No (If yes check all that apply)

- ☐ Asbestosis
- ☐ Pneumonia
- ☐ Silicosis
- ☐ Pneumothorax
- ☐ Lung cancer
- ☐ Broken ribs
- ☐ Shortness of Breath
- ☐ Persistent Cough
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Emphysema
- ☐ Trouble smelling orders
- ☐ Any chest injuries or surgeries
- ☐ Any other lung problem that you've been told about
- ☐ Allergic reactions that interfere with your breathing

Do you currently have any of the following symptoms of pulmonary or lung illness? ☐ Yes ☐ No (If yes check all that apply)

- ☐ Persistent Cough
- ☐ Coughing up Blood in the last month
- ☐ Coughing up Sputum
- ☐ Wheezing
- ☐ Wheezing that interferes with your job
- ☐ Chest pain when you breathe deeply
- ☐ 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 other people at an ordinary pace on level ground
- ☐ Have to stop for breath when walking at your own pace on level ground
- ☐ Shortness of breath when washing or dressing yourself
- ☐ Shortness of breath that interferes with your job
- ☐ Coughing that wakes you early in the morning
- ☐ Coughing that occurs mostly when you are lying down
- ☐ Any other symptoms that you think may be related to lung problems

Name:_____ Social Security Number:_____-_____-_____ Page
(Last) (First) (Initial)

Have you ever had any of the following cardiovascular or heart problems? ☐ Yes ☐ No (If yes check all that apply)

- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Palpitations
- ☐ Unusually Rapid Heart Beat
- ☐ Heart Attack
- ☐ Angina
- ☐ Heart Failure
- ☐ Varicose Veins
- ☐ Phlebitis
- ☐ Congenital heart problem
- ☐ Other heart problem
- ☐ Stroke
- ☐ Heart failure
- ☐ Heart Arrhythmia
- ☐ Any other heart problem that you've been told about

Have you ever had any of the following cardiovascular or heart symptoms? ☐ Yes ☐ No (If yes check all that apply)

- ☐ Frequent pain or tightness in your 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 that you think may be related to heart or circulation problems
- ☐ High Blood Pressure?

Problem with the Stomach, Liver or Bowels? ☐ Yes ☐ No (If yes check all that apply)

- ☐ Stomach/Abdominal Pain/Discomfort
- ☐ Stomach Ulcer
- ☐ Persistent Diarrhea
- ☐ Blood in Stool
- ☐ Cirrhosis
- ☐ Recent Change in Bowel Habits
- ☐ Hepatitis
- ☐ Yellow Jaundice
- ☐ Gallbladder Trouble
- ☐ Hernia
- ☐ Heartburn

Problems with the Bladder or Kidneys? ☐ Yes ☐ No (If yes check all that apply)

- ☐ Urine Infection
- ☐ Frequent Urination
- ☐ Kidney stone
- ☐ Painful Urination
- ☐ Blood in the Urine
- ☐ Difficulty Urinating
- ☐ Kidney Failure

(Men) Problem with the Male Organs? ☐ Yes ☐ No (If yes check all that apply)

- ☐ Infertility (inability to have children)
- ☐ Trouble with Sexual Performance
- ☐ Prostate Infection
- ☐ Prostate Enlargement
- ☐ Lump on Testicle

(Women) Problem with Female Organs? ☐ Yes ☐ No (If yes check all that apply)

- ☐ Infertility (inability to have children)
- ☐ Pelvic Infections
- ☐ Painful Periods
- ☐ Missed, Irregular, Prolonged Periods
- ☐ Breast Lumps or Discharge

(Women) Are you pregnant now? ☐ Yes ☐ No

Problems with the Nervous System? ☐ Yes ☐ No (If yes check all that apply)

- ☐ Seizures or Convulsions
- ☐ Epilepsy
- ☐ Headaches
- ☐ Stroke
- ☐ Fainting or Blackouts
- ☐ Numbness or Loss of Sensation
- ☐ Weakness of Arm or Leg
- ☐ Neurologic disorder (nerve or brain disease)

Emotional or Mental Problems? ☐ Yes ☐ No (If yes check all that apply)

- ☐ Depression
- ☐ Anxiety
- ☐ Nervous Breakdown
- ☐ Claustrophobia (fear of closed-in places):

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Any other Problem with Pain? ☐ Yes ☐ No (If yes check all that apply)
☐ Pain/Discomfort in the Chest ☐ Pain in the Arms or Legs

Any Swelling in the Legs? ☐ Yes ☐ No

History of Any Kind of Cancer? ☐ Yes ☐ No

Persistently Swollen Lymph Glands? ☐ Yes ☐ No

Problem with the Thyroid Gland? ☐ Yes ☐ No

Any Other Health Problems? ☐ Yes ☐ No

Use this space to explain any special problem or to complete other sections as needed.

HABITS AND LIFE-STYLE

Tobacco:

Have you ever smoked? ☐ Yes ☐ No If yes, what and how much did you smoke?

_____ Cigarettes/day _____Cigars/day _____Pipe bowls/day How many total years have you smoked?_____

Have you ever chewed snuff/tobacco? ☐ Yes ☐ No _____cans (pouches) / week for _____years

Alcohol:

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, what and how much do you drink?

_____Beers _____Glasses of wine _____Mixed drinks

Never ☐ Very Seldom ☐ 1-3 Days/Week ☐ Daily ☐

Fitness:

How much do you exercise?

_____times per week for_____hours/minutes Type of exercise_____(i.e. running, aerobics, etc.)

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PERFORMANCE CRITERIA FOR FIREFIGHTERS

If you have used a respirator, have you ever had any of the following problems? (Check all that apply)

Used a respirator ☐ Yes ☐ No
Eye irritation ☐
Skin allergies or rashes ☐
Anxiety ☐
General weakness or fatigue ☐
Any other problem that interferes with your use of a respirator ☐

Do you have any physical or mental *condition* that would hamper your ability to do any of the following? (if yes check all that apply)

Use self-contained breathing apparatus (SCBA) ☐
Run ☐
Stand continuously for three (3) hours ☐
Keep balance ☐
Crawl ☐
Kneel ☐
Climb/work at heights greater than 10 feet ☐
Work in tight or enclosed places ☐
Reach above shoulder height with both arms ☐
Fully use both hands ☐
Use heavy exertion suddenly and continuously ☐

Is there any reason that you cannot work under any of the following environmental conditions? (If yes check all that apply)

Very dry air ☐
Very humid air ☐
On slippery surfaces ☐
Heat ☐
Cold ☐
Very bright light ☐
Very dim light ☐
Noise ☐
Dust ☐
Smoke ☐

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

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

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:_____

Have you ever worked with any of the materials, or under any of the conditions, listed below? ☐ Yes ☐ No (If yes check all that apply)

☐ Radiation
☐ Pesticides
☐ PCB, PBB
☐ Noise
☐ Carcinogens
☐ Vapors/Gases
☐ Vibration
☐ Asbestos
☐ Silica (e.g., in sandblasting)
☐ Beryllium
☐ Aluminum
☐ Coal (for example, mining)
☐ Iron
☐ Tin
☐ Dusty environments
☐ Tungsten/cobalt (e.g., grinding or welding this material)
☐ Any other hazardous exposures

If "yes," describe these exposures: _____

_____

List any second jobs or side businesses you have: _____

Name:_____ Social Security Number:_____-_____-_____ Page
(Last) (First) (Initial)

List your previous occupations:_____

_____

List your current and previous hobbies: _____

_____

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

Have you ever worked on a HAZMAT team? ☐ Yes ☐ No

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

HEPA Filters ☐ Yes ☐ No Cartridges ☐ Yes ☐ No

Canisters (for example, gas masks) ☐ Yes ☐ No

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

Escape only (no rescue) ☐ Yes ☐ No Less than 2 hours per day ☐ Yes ☐ No

Emergency rescue only ☐ Yes ☐ No 2 to 4 hours per day ☐ Yes ☐ No

Less than 5 hours per week ☐ Yes ☐ No Over 4 hours per day ☐ Yes ☐ No

During the period you are using the respirator(s), is your work effort?

Light (less than 200 kcal per hour) ☐ Yes ☐ No

If "yes," how long does this period last during the average shift:_____hrs._____min.

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 to 350 kcal per hour) ☐ Yes ☐ No

If "yes," how long does this period last during the average shift:_____hrs._____min.

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

Heavy (above 350 kcal per hour) ☐ Yes ☐ No

If "yes," how long does this period last during the average shift:_____hrs._____min.

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.).

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: _____

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

Will you be working under humid conditions ☐ Yes ☐ No

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

_____

_____

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

_____

_____

Provide the following information, if you know it, for each toxic substance that 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 that you'll be exposed to while using your respirator:

_____

_____

_____

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

_____

Name:_____ Social Security Number:_____-_____-_____
(Last) (First) (Initial)

I certify the information contained in this record is correct and complete to the best of my knowledge and belief. I understand that knowingly making a false statement in this record shall be deemed sufficient cause for rejection of my application or dismissal after employment, and forfeiture of any and all workers' compensation benefits which I may be entitled to pursuant to law. I understand that Bernalillo County will rely on this Medical and Occupational History.

I AUTHORIZE BERNALILLO COUNTY, NOW AND IN THE FUTURE, TO OBTAIN ANY MEDICAL RECORDS WHICH ARE REASONABLY RELATED TO MY ABILITY TO DO MY JOB.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT.

_____ _____
Date Signature of Applicant

MEDICAL SCREENING FORM FOR FIREFIGHTERS
PHYSICIAN'S CERTIFICATION CRITERIA FOR FIREFIGHTERS

Hearing threshold level (corrected) in both ears not over 30 dB average at 500, 1000 and 2000 Hz, with no single frequency over 35 dB and not over 55 dB at 4,000 Hz based on the zero reference level as specified in the American National Standards Institute (ANSI) 53.6-1969 (R1973) "Specifications for Audiometers".

Vision acuity worse than 20/30 (corrected) or 20/200 (uncorrected) in either eye. (Contact lenses are not permitted.)

Cardiovascular disease including (a) either history or electrocardiographic evidence of myocardial infraction or angina pectoris, (b) abnormal electrocardiogram with dysrhythmia, conduction block, or chamber hypertrophy, unless specifically waived as being at risk for firefighting duties by a physician, and (c) systemic arterial hypertension uncontrolled down to levels below 150 mm Hg systolic and 100 mm Hg diastolic blood pressure.

Seizure disorder of any type unless free of seizures and not taking anti-seizure medication throughout previous five (5) years

Chronic obstructive or chronic restrictive lung disease with vital capacity or forced expiratory volume in one second (FEV) less than 75% predicted, or bronchial asthma requiring chronic or intermittent medication.

Name:_____ Social Security Number:_____-_____-_____
(Last) (First) (Initial)

BERNALILLO COUNTY FIRE DEPARTMENT

Physical Examination

Date:_____ M_____ F_____

Position applied for:_____ Classification: S L M H V

VISION:_____ Uncorrected _____ Corrected _____

Distant	R 20/≤200	L 20/≤200	Both 20/	R 20/≤30	L 20/≤30	Both 20/
Near	R 20/≤200	L 20/≤200	Both 20/	R 20/≤30	L 20/≤30	Both 20/

Color Vision:_____ Depth Perception:_____

Audiogram:_____

Urinalysis: = Negative

Glucose	pH	5	6	6.5	7.0	8.0	8.5	
Bilirubin	Specific Gravity	1.00	1.005	1.010	1.015	1.020	1.025	1.030
Ketone	Protein							
Blood	Urobilinogen							
Protein	Nitrite							

Other Lab Results_____

Height_____ Weight_____

Systolic Blood Pressure (sitting)_____ Greater than 150mmHg ☐ Yes ☐ No

Diastolic blood pressure (sitting)_____ Greater than 100mmHg ☐ Yes ☐ No

Pulse (sitting) _____ Greater than 95 beats/min ☐ Yes ☐ No

Mount PFT and Audio strips in the spaces below:

N –NORMAL A = ABNORMAL NE - NOT EXAMINED

1. HEENT	N	A	NE	5. Abdomen	N	A	NE	9. Neurological	N	A	NE
2. Neck	N	A	NE	6. Hernia	N	A	NE	10. Integument	N	A	NE
3. Chest	N	A	NE	7. Back	N	A	NE	11. Other	N	A	NE
4. Heart	N	A	N E	8. Musculoskeletal	N	A	NE				

List abnormals below:

_____

_____

_____

ISTU_____ Pass_____ Fail_____ Not applicable_____
Audiogram_____ Pass_____ Fail_____ Not applicable_____
Pulmonary Fnct..._____ Pass_____ Fail_____ Not applicable_____
CXR_____ Normal_____ Abnormal_____ Not applicable_____
EKG_____ Normal_____ Abnormal_____ Not applicable_____

Recommendations:

_____

_____

_____

_____

Passed ☐ Failed ☐ Signature_____ Date_____