BUTTE COUNTY RESPIRATORY PROTECTION PROGRAM
MEDICAL QUESTIONNAIRE FOR VOLUNTEER FIRE FIGHTER RESPIRATOR USERS

Volunteer Fire Fighter's Name:		**Date:**
Home Address:		**Department:** Butte County Fire Department **Volunteer Company:**
Home Phone:		**Work Phone:**
Date of Birth:	**Age:**	**Job Title:** Volunteer Fire Fighter
SSN:		

TO THE VOLUNTEER FIRE FIGHTER:
Your Supervisor must allow you to answer the questionnaire at a time and place that is convenient to you. To maintain your confidentiality your supervisor must not look at or review your answers, and your supervisor must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. SECTION 1 (MANDATORY)
The following information must be provided by every volunteer fire fighter who has been selected to use any type of respiratory (please print).

1. Gender ☐Male ☐Female
2. Height_____ft._____inches

3. Your weight_____

4. Check the type of respirator you will use (you can check more than one category).
   a. ☐N, R, or P disposable respirator (filter-mask, noncartridge type only)
   b. ☐Half or full-face piece air-purifying type
   c. ☐Powered air purifying, supplied air
   d. ☐Self-Contained breathing apparatus (SCBA)

5. Have you ever worn a respirator? ☐Yes ☐No

6. Have you worn one in a simulated or actual firefighting situation? ☐Yes ☐No
   a. ☐N, R, or P disposable respirator (filter-mask, non-cartridge type only)
   b. ☐Half or full-face piece air-purifying type
   c. ☐Powered-air purifying supplied air
   d. ☐Self-contained breathing apparatus (SCBA)

PART A. SECTION 2 (MANDATORY)

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? ☐Yes ☐No
   a. If "yes", what quantity (how many cigarettes a day?)_____
   b. If you did smoke tobacco and quit, how long has it been since you last smoked? _____

2. Have you ever had any of the following conditions:	
a. Seizures	☐Yes ☐No
b. Diabetes	☐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 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	☐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 you've been told about	☐Yes ☐No
4. Do you currently have any of the following symptoms:	
a. Shortness of breath	☐Yes ☐No
b. Shortness of breath when walking fast on level ground or up a slight hill	☐Yes ☐No
c. Shortness of breath with walking with other people at an ordinary pace on level ground	☐Yes ☐No
d. Have you had 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 a thick sputum	☐Yes ☐No
h. Coughing that wakes you early in the morning	☐Yes ☐No
i. Coughing that occurs mostly when you are laying down	☐Yes ☐No
j. Coughing up blood in the last month	☐Yes ☐No
k. Wheezing that interferes with your job	☐Yes ☐No
l. Wheezing	☐Yes ☐No
m. Chest pain when you breathe deeply	☐Yes ☐No
5. Have you ever had any of the following problems: If "yes"	
a. Heart Attack	☐Yes ☐No Year_____

b. Stroke	☐Yes ☐No Year_____
c. Angina	☐Yes ☐No Year_____
d. Heart failure	☐Yes ☐No Year_____
e. Swelling in your hands or feet (not caused by walking)	☐Yes ☐No Year_____
f. Irregular heart beat	☐Yes ☐No Year_____
g. High blood pressure	☐Yes ☐No Year_____
h. Any heart problems you have been told about	☐Yes ☐No Year_____
6. Have you ever had any of the following symptoms, (if "yes) give date of most recent symptom)	
a. Frequent pain or tightness in your chest	☐Yes ☐No Date_____
b. Pain or tightness in your chest during physical activity	☐Yes ☐No Date_____
c. Pain or tightness in your chest that interferes with your job	☐Yes ☐No Date_____
d. In the past two years have you noticed your heart skipping or missing a beat	☐Yes ☐No Date_____
e. Heartburn or indigestion that is not related to eating	☐Yes ☐No Date_____
f. Any other symptom that you think may be related to heart or circulation problems	☐Yes ☐No Date_____
7. Do you currently take medications for any of the following problems, if so please indicate the medication	
a. Breathing or lung problems_____	☐Yes ☐No
b. Heart problems_____	☐Yes ☐No
c. Blood pressure_____	☐Yes ☐No
d. Seizures_____	☐Yes ☐No
8. If you have EVER used a respirator, have you ever had	
a. Eye irritation	☐Yes ☐No
b. Skin allergies or rashes	☐Yes ☐No
c. General weakness or fatigue	☐Yes ☐No
d. Any other problems that interferes with your use of a respirator	☐Yes ☐No
9. Would you like to talk to the health care professional that will review this questionnaire?	☐Yes ☐No

PART B	
1. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals, or have you come into skin contact with hazardous chemicals. It YES, please name them	
a. Asbestos	☐Yes ☐No
b. Silica	☐Yes ☐No
c. Lead	☐Yes ☐No
d. Pesticides	☐Yes ☐No
e. Glues and adhesives	☐Yes ☐No
f. Clandestine drug labs	☐Yes ☐No
g. Dusty environments	☐Yes ☐No
h. Other_____	☐Yes ☐No
2. List any jobs or side business you have _____	
3. List your previous occupation_____	
4. Have you ever worked on a hazmat team?	☐Yes ☐No
5. Other than the medications mentioned earlier in this questionnaire, are you taking any other medication for any reason (including over-the-counter medications). If YES, list them _____ _____ _____ _____ _____ _____	
6. How often are you expected to use the respirator(s) mark 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 5 hours per week	☐Yes ☐No
d. Less than 2 hours per day	☐Yes ☐No
e. 2 to 4 hours per day	☐Yes ☐No
f. Over 4 hours per day	☐Yes ☐No

7. During the period you are using the respirator, is your activity LIGHT, MODERATE, or HEAVY. How long does this period last during the average shift? **LIGHT**=sitting while working or performing light assembly work or standing while operating machinery (1-3 lbs.) **MODERATE**=Driving truck or bus, standing while performing work, operating machinery (35 lbs.) walking on a level surface about 2mph or down a 5-degree grade about 3mph or pushing a wheelbarrow with a heavy load (100 lbs.) on a level surface. **HEAVY**= Lifting a heavy load (about 50lbs.) from the floor to your waist. Or working on a loading dock, walking up an 8-degree angle, about 2mph, climbing stairs with a 50lb load.	☐ Light How long does this period last during your shift_____ ☐Moderate How long does this period last during your shift_____ ☐Heavy How long does this period last during your shift_____
8. Will you be working under temperature conditions exceeding 77 degrees?	☐Yes ☐No
9. Will you be working under humid conditions?	☐Yes ☐No
10. Describe the work you will be doing while you are using the respirator(s)_____	
11. Describe any special or hazardous conditions you might encounter when you are using your respirator(s) for example, confined spaces, life-threatening gasses. _____ _____ _____	
PART C. (FULL-FACEPIECE RESPIRATORS AND SCBA'S)	
1. Have you ever lost vision in either eye? If YES, date and type of problem _____	☐Yes ☐No
2. Do you currently have any of the following:	
a. Wear eye glasses and/or contact lenses. If YES date of last eye exam _____	☐Yes ☐No
b. Color blind	☐Yes ☐No
c. Any other eye or vision problems	☐Yes ☐No

3. Have you ever had an injury to your ears, including a broken ear drum? If YES, include date of injury_____	☐Yes ☐No
4. Do you currently have any of the following hearing problems	
a. Difficulty hearing	☐Yes ☐No
b. Wearing a hearing aid	☐Yes ☐No
c. Any other hearing or ear problem	☐Yes ☐No
5. Have you ever had a back injury?	☐Yes ☐No
6. 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 moving your arms and legs	☐Yes ☐No
d. Pain or stiffness when you lean forward	☐Yes ☐No
e. Difficulty moving your head up or down	☐Yes ☐No
f. Difficulty 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 lbs.	☐Yes ☐No
j. Any other muscle or skeletal problem that would interfere with using a respirator	☐Yes ☐No
7. Have you ever had back surgery	☐Yes ☐No
8. Do you have any medical work restrictions?	☐Yes ☐No

CERTIFICATION: I CERTIFY THAT I HAVE PROVIDED TRUE AND COMPLETE INFORMATION CONCERNING MY HEALTH

VOLUNTEER FIRE FIGHTER SIGNATURE _____ DATE _____

REVIWER'S SIGNATURE _____ DATE _____