

**INFORMATION SHEET**

SOCIAL SECURITY #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / 19 \_\_\_\_ Employee ID# \_\_\_\_

NAME: \_\_\_\_\_  
 (Last) (First) (Middle)

ADDRESS: \_\_\_\_\_  
 (Street or Mailing) (City/ST) (Zip Code)

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ E-MAIL: \_\_\_\_\_

Location: Please  (1) Box

- Baptist  South Miami  Doctors  Homestead  Mariners  BOS / BHE  Corporate

DATE of Hire: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ JOB TITLE: \_\_\_\_\_ DEPARTMENT: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_ LATEX allergy:  YES  NO

CURRENT MEDS: \_\_\_\_\_ Drug Screen Date \_\_\_\_\_  Neg  Pos

**DO NOT WRITE BELOW THIS SECTION – OFFICIAL EMPLOYEE HEALTH USE ONLY**

PPD – Step 1		PPD – Step 2		CHEST X-RAY	FINDINGS
<input type="checkbox"/> PPD GIVEN	/ /	<input type="checkbox"/> PPD GIVEN	/ /	/ /	
Erythema ____ mm	Induration ____ mm	Erythema ____ mm	Induration ____ mm	/ /	

TB SCREENING										
DATE	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Induration	____ mm	____ mm	____ mm	____ mm	____ mm	____ mm	____ mm	____ mm	____ mm	____ mm
Erythema	____ mm	____ mm	____ mm	____ mm	____ mm	____ mm	____ mm	____ mm	____ mm	____ mm
Hx POS S&S	y / n	y / n	y / n	y / n	y / n	y / n	y / n	y / n	y / n	y / n

ANTIBODY & VACCINE RECORD					
NAME	TITER DATE	FINDINGS	VACCINE DATE	TITER Re-DRAW	FINDINGS
RUBELLA IgG	/ /		/ /	/ /	
RUBEOLA IgG	/ /		/ /	/ /	
VARICELLA IgG	/ /		/ /	/ /	
HEPATITIS B Antibody	/ /		/ /	/ /	

VARICELLA Vaccine	MMR Vaccine	HEPATITIS B			
		SERIES #1	COMMENTS	SERIES #2	COMMENTS
#1 / /	#1 / /	/ /		/ /	
#2 / /	#2 / /	/ /		/ /	
Decl. / /	Decl. / /	/ /		/ /	

<b>Tetanus-Dip</b>	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
<b>Influenza Vaccine</b>	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /

FIT TEST RECORD									
/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Mask ____	Mask ____	Mask ____	Mask ____	Mask ____	Mask ____	Mask ____	Mask ____	Mask ____	Mask ____
Size ____	Size ____	Size ____	Size ____	Size ____	Size ____	Size ____	Size ____	Size ____	Size ____
Test / Check	Test / Check	Test / Check	Test / Check	Test / Check	Test / Check	Test / Check	Test / Check	Test / Check	Test / Check

**VITALS & VISION SHEET**

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_  MALE  FEMALE      Height \_\_\_' \_\_\_"      Weight \_\_\_\_\_ Lbs

**DO NOT WRITE BELOW THIS SECTION - OFFICIAL EMPLOYEE HEALTH USE ONLY**

BP \_\_\_\_\_      Pulse \_\_\_\_\_      Temp \_\_\_\_\_

DATE: \_\_\_\_\_      Recheck BP \_\_\_\_\_      Pulse \_\_\_\_\_

Vision: Right Eye \_\_\_/\_\_\_      Left Eye \_\_\_/\_\_\_      Both Eyes \_\_\_/\_\_\_

With Contacts \_\_\_\_\_      With Glasses \_\_\_\_\_

***COLOR BLIND TESTING-Ishihara Test***

PLATE No.	NUMBER READ	RESULTS / comments
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

Examining Practioner: \_\_\_\_\_

Pass       FAIL

**HEALTH HISTORY & SCREENING - STATEMENT**

Name \_\_\_\_\_

Date \_\_\_\_\_

Welcome to BAPTIST HEALTH. Employee Health Services is here to provide health care for you. We are available for consultation, medical referrals, care and treatment.

- Please take your time and carefully read the following health history form.
- Answer all questions. We are available to assist you if necessary.

***Please initial at the end of each statement:***

- 1) Your answers to the following questions are to assist in placing you in a job safe to you and to others. \_\_\_\_\_ (Initial)
- 2) I understand such information pertinent to my job description may be made available to my supervisor. \_\_\_\_\_ (Initial)
- 3) I authorize Employee Health Services to perform any physical and/or laboratory examination, which is necessary to verify the absence of communicable disease or any condition, which might impair the performance of my duties as an employee of BAPTIST HEALTH. \_\_\_\_\_ (Initial)
- 4) I understand that any offer of employment is conditional upon satisfactorily completing the health assessment. \_\_\_\_\_ (Initial)

**HEALTH HISTORY & SCREENING**

Name \_\_\_\_\_

Date \_\_\_\_\_

**SOCIAL SECURITY #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**HISTORY**

1. Have you ever had a back condition or injury?  No  YES Year \_\_\_\_\_.

List condition or injury: \_\_\_\_\_

Describe incidents: \_\_\_\_\_

\_\_\_\_\_

Did you consult with a physician regarding your back problem?  No  YES

Physician's name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Describe type of treatment \_\_\_\_\_

Did you have any X-RAY, MRI, and/or CT? \_\_\_\_\_

Previous back surgery? \_\_\_\_\_

2. Have you ever had a neck condition or injury?  No  YES Year \_\_\_\_\_.

List condition or injury: \_\_\_\_\_

Describe incidents: \_\_\_\_\_

Did you consult with a physician regarding your neck problem?  No  YES

Physician's name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Describe type of treatment \_\_\_\_\_

Did you have any X-RAY, MRI, and/or CT? \_\_\_\_\_

Previous neck surgery? \_\_\_\_\_

3. Do you still suffer effects from the back / neck problem described above?  No  YES

4. If so, check symptoms and severity (1-10) you continue to experience at time : 1=MILD- 10=SEVERE

\_\_\_\_\_ Weakness                      \_\_\_\_\_ Tingling                      \_\_\_\_\_ Soreness after lifting

\_\_\_\_\_ Dizziness                      \_\_\_\_\_ Pain with lifting

\_\_\_\_\_ Numbness                      \_\_\_\_\_ Pain with Coughing

\_\_\_\_\_ Headache                      \_\_\_\_\_ Tiredness after work

5. Do you take any medications for your back / neck condition?  No  YES

List medications: \_\_\_\_\_ How often taken: \_\_\_\_\_

6. Do you have trouble performing the Activities of Daily Living?  No  YES

Describe limitations \_\_\_\_\_

7. Have you ever been unable to work because of condition or injury?  No  YES

Examiner's Comment: \_\_\_\_\_

**HEALTH HISTORY & SCREENING** *continued . . .*

<u>YES</u>	<u>NO</u>	DO YOU HAVE OR HAD THE FOLLOWING:	<u>Applicant's Comment</u>	<u>Examiner's Comment</u>
<u>RESPIRATORY CONDITION(s):</u>				
1.		Asthma		
2.		Emphysema		
3.		Bronchitis		
4.		Smoker? / How long?		
5.		Tuberculosis		
6.		Other		
<u>CARDIAC CONDITION(s):</u>				
1.		High Blood Pressure		
2.		Heart Condition		
3.		Congestive Heart Failure (CHF)		
4.		Open Heart Surgery		
5.		Heart Attack		
6.		Chest Pain		
7.		Other		
<u>NEURO/MUSCULAR, SKELETAL &amp; JOINT CONDITION(s)</u>				
1.		Hand/Wrist Injury; Carpal Tunnel		
2.		Shoulder / Elbow Injury		
3.		Back Sprain		
4.		Back-Herniated Intervertebral Disc		
5.		Back-Surgical Procedure		
6.		Broken Bones		
7.		Knee Injury		
8.		Ankle Injury		
9.		Leg injury		
10.		Hip Disorder		
11.		Foot Problem		
12.		Amputation of Foot/Leg/Arm/Hand		
13.		Neck injury or pain		
14.		Orthopedic surgery		
15.		Poliomyelitis – Residual Disability		
16.		Arthritis/ Gout		
17.		Chronic Osteoarthritis		
18.		Other		

**COMMENTS:** Please include any testing (x-ray, CT, MRI, etc), Physician name and address, tel. #, fax #

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**BHSF Employee Health Services HEALTH HISTORY & SCREENING**

Name: \_\_\_\_\_

<u>YES</u>	<u>NO</u>	DO YOU HAVE OR HAD THE FOLLOWING:	<u>Applicant's Comment</u>	<u>Examiner's Comment</u>
<b>ABDOMINAL CONDITION(s):</b>				
1.		Stomach and/or Intestinal disorder		
2.		Irritable Bowel Syndrome		
3.		Colitis		
4.		Crohns		
5.		Gall Bladder		
6.		Ulcer		
7.		Kidney Disease		
8.		Hernia		
9.		Hepatitis		
10.		Liver Disease		
11.		Other		
<b>MEDICAL CONDITION(s):</b>				
1.		Diabetes		
2.		Epilepsy / Seizure Disorder		
4.		Headaches / Migraines		
5.		Head Injury		
6.		Vascular Disorder		
7.		Stroke (CVA)		
7.		Thrombophlebitis (Blood clot)		
8.		Anemia		
9.		Circulatory problems		
10.		Bleeding disorder		
11.		Cancer		
12.		Immunosuppressive condition		
<b>Other:</b>				
1.		Deafness--total or partial hearing		
2.		Ear Condition		
3.		Eye Condition		
4.		Total or partial loss of sight		
5.		Color Blind (Color Deficiency)		
<b>FAMILY HISTORY:</b>				
1.		Cancer		
2.		Heart Disease		
3.		High Blood Pressure		
4.		Diabetes		
5.		Other Serious Illness		
<b>PAST HISTORY:</b>				
1.		Are you currently or have you ever been under the supervision of IPN, PRN, or the Department of Health? If yes, please explain circumstances, including dates.		
<b>WOMEN ONLY:</b>				
		Are you pregnant? If YES; Estimated date due _____		

**BHSF Employee Health Services**

**HEALTH HISTORY & SCREENING**

Name: \_\_\_\_\_

**LIST ALL:**

Examiner's Comment

Surgical Procedures: \_\_\_\_\_  
\_\_\_\_\_

Car Accident: \_\_\_\_\_  
\_\_\_\_\_

Other Accidents: \_\_\_\_\_  
\_\_\_\_\_

Any other Illness or Condition not listed? \_\_\_\_\_

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**WORKERS' COMPENSATION:**

**Please Note: Baptist Health South Florida requires copies of any workman's compensation claim, medical records, and work release.**

Have you ever had any Workers' Compensation injuries/or claims?  No  YES (describe below)

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<u>Date</u>	<u>Injury</u>	<u>Company</u>	<u>State</u>
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Did you file a lawsuit against your employer in any Workers' Compensation case?  No  YES

Will any condition limit you in any way in the performance of your specific job description?  No  YES

EXPLAIN

\_\_\_\_\_  
\_\_\_\_\_

**BHSF Employee Health Services HEALTH HISTORY & SCREENING**

Name: \_\_\_\_\_

**ADA ACCOMMODATIONS:**

1) I have received, read, and understand my job description as well as the essential functions of the job; I feel I can perform these functions.  No  YES

2) Will any personal physical/emotional condition limit you in any way in the performance of your specific job description?  No  YES (describe below)

\_\_\_\_\_

3) Have you ever been unable to work because of an illness, injury, or condition?  No  YES (describe below)

\_\_\_\_\_

4) Do you feel you need to have a reasonable accommodation(s) to perform the essential functions of this job?  No  YES (describe below)

**COMMENTS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I CERTIFY THAT THIS HEALTH HISTORY IS TRUE AND COMPLETE AND THAT I DO NOT HAVE ANY ILLNESS, INJURY OR CHRONIC DISEASE OTHER THAN STATED WITHIN THIS DOCUMENT. I UNDERSTAND THAT FALSIFICATION OF AND/OR FAILURE TO PROVIDE ANY INFORMATION IS GROUNDS FOR IMMEDIATE DISMISSAL OR COULD RESULT IN DENIAL OF WORKERS COMPENSATION BENEFITS. I ALSO UNDERSTAND THAT THE JOB OFFER IS CONTINGENT UPON SUCCESSFUL COMPLETION OF AND VERIFICATION OF DATA PROVIDED IN THE POST OFFER SCREENING. I AUTHORIZE MEDICAL INFORMATION OBTAINED DURING MY SCREENING MAY BE DISCLOSED ONLY TO THE EXTENT NECESSARY, TO DETERMINE MY ABILITY TO PERFORM ESSENTIAL FUNCTIONS OF MY INTENDED POSITION. I UNDERSTAND THAT THIS SCREENING IS COMPLETED TO DETERMINE MY ABILITY TO PERFORM ESSENTIAL FUNCTIONS OF MY INTENDED POSITION AND DOES NOT CONSTITUTE A COMPLETE AND COMPREHENSIVE MEDICAL EXAMINATION. IT IS NOT INTENDED FOR USE TO DETERMINE THE STATUS OF MY OVERALL PERSONAL HEALTH.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Examiner \_\_\_\_\_

**CONSENT to DRUG & ALCOHOL SCREENING  
AND  
RELEASE of BAPTIST HEALTH SOUTH FLORIDA**

Statement of Policy

It is the policy of BAPTIST HEALTH SOUTH FLORIDA to screen all job applicants for use of illegal drugs and alcohol abuse. This screening will normally be conducted by obtaining urine samples and performing tests thereon (a description of the procedures and the Hospital's policies is available if requested).

Conditions of Employment

All job applicants must execute this consent and release and must comply with the testing procedures of BAPTIST HEALTH SOUTH FLORIDA before they will be considered for employment. Applicants who refuse will not be considered for employment by BAPTIST HEALTH SOUTH FLORIDA. No guarantee is made that an applicant who passes the tests will be hired (an applicant who fails to pass the tests will not be employed unless, in the sole discretion of BAPTIST HEALTH SOUTH FLORIDA, special circumstances exist).

Result Confidential

The results of the tests will be placed in an applicant's employment file if hired, or in a file maintained by the Employee Health Services if the applicant is not hired. The results of the test will not be released to any outside parties.

Consent

I hereby consent to being tested for illegal drugs and alcohol abuse, and agree to abide by the testing procedures of BAPTIST HEALTH SOUTH FLORIDA. I acknowledge that failure to comply with these procedures will result in my not being eligible for employment at BAPTIST HEALTH SOUTH FLORIDA.

Release

I release BAPTIST HEALTH SOUTH FLORIDA and its trustees, officers, employees and agents from any and all claims, liabilities and causes of action of any nature whatsoever in connection with a) this consent, b) the performing of drug and alcohol test in connection therewith and c) my not being employed by BAPTIST HEALTH SOUTH FLORIDA if, in the sole opinion of BAPTIST HEALTH SOUTH FLORIDA, I fail to meet any of the requirements established by BAPTIST HEALTH SOUTH FLORIDA in connection with such tests.

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Name of Applicant (PRINT CLEARLY)

**LATEX ALLERGY HISTORY SCREENING**

Name \_\_\_\_\_

Date \_\_\_\_\_

**SOCIAL SECURITY #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Have you ever had a reaction such as swelling, itching, or difficulty breathing when exposed to latex material such as rubber gloves or balloons?     YES     No

*Describe any reactions you may have had to the following materials or foods:*

	<u>NONE</u>	<u>Localized</u> hives ( <i>describe</i> ) or redness, itching or burning rash	<u>Systemic</u> difficulty breathing, wheezing, facial swelling, nasal congestion, tearing or shock ( <i>describe</i> )
Balloons	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Rubber Gloves	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Band-Aids	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Elastic Materials	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Dental Devices	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Condoms	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Avocados	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Bananas	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Kiwi Fruit	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Papayas	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Chestnuts	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____
OTHER	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> _____

Do you have a history of:

- |                              |                             |   |                              |                             |  |
|------------------------------|-----------------------------|---|------------------------------|-----------------------------|--|
| <input type="checkbox"/> YES | <input type="checkbox"/> No | Hay Fever   | <input type="checkbox"/> YES | <input type="checkbox"/> No | Autoimmune Disease                                 |
| <input type="checkbox"/> YES | <input type="checkbox"/> No | Eczema  | <input type="checkbox"/> YES | <input type="checkbox"/> No | Multiple Drugs Allergies                           |
| <input type="checkbox"/> YES | <input type="checkbox"/> No | Asthma  | <input type="checkbox"/> YES | <input type="checkbox"/> No | Numerous Medical/Surgical Procedures               |
| <input type="checkbox"/> YES | <input type="checkbox"/> No | Contact Dermatitis  | <input type="checkbox"/> YES | <input type="checkbox"/> No | Occupational Exposure to Latex Products            |
| <input type="checkbox"/> YES | <input type="checkbox"/> No | Rhinitis/Conjunctivitis   | <input type="checkbox"/> YES | <input type="checkbox"/> No | Congenital abnormality ( <i>i.e.</i> Spina Bifida) |
| <input type="checkbox"/> YES | <input type="checkbox"/> No | Severe or unexplained reactions (shock) during medical or dental work |                              |                             |  |

Have you ever had:

- |                              |                             |                          |                |
|------------------------------|-----------------------------|--------------------------|----------------|
| <input type="checkbox"/> YES | <input type="checkbox"/> No | General Allergy Testing? | Results: _____ |
| <input type="checkbox"/> YES | <input type="checkbox"/> No | Latex-Allergy Testing?   | Results: _____ |
| <input type="checkbox"/> YES | <input type="checkbox"/> No | Allergy Treatment        | _____          |

Are you currently being treated by an allergist or dermatologist on a regular basis?

Physician's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Signature: \_\_\_\_\_ Name(s) of Physician(s) Notified: \_\_\_\_\_

**MEDICAL QUESTIONNAIRE for RESPIRATOR USERS**

Your name: \_\_\_\_\_ Today's date: \_\_\_\_\_

 Your job title: \_\_\_\_\_ Sex (*circle one*): Male / Female

Your age: \_\_\_\_\_ Your height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Your weight: \_\_\_\_\_ lbs

✓ A phone number (including area code) where you can be reached by the health care professional who reviews this questionnaire: \_\_\_\_\_

✓ What is the best time to phone you at this number: \_\_\_\_\_

Has your employer told you how to contact the health care professional who will review this questionnaire  
(*please check "Yes" or "No"?*)  Yes  No

1. Check the type of respirator you will use (you may select more than one category):
- \_\_\_ N.R. or P disposable respirator (*e.g.* filter-mask, non-cartridge type only)
  - \_\_\_ Other type (*e.g.* half-or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

2. Have you worn a respirator (*please check "Yes" or "No"?*)  Yes  No  
If "Yes" what type(s) \_\_\_\_\_

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**PART A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by the employee who has been selected to use any type of respirator (*please check "Yes" or "No"*).**


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- Do you currently smoke tobacco, or have you smoked tobacco in the last month:  Yes  No
- Have you ever had any of the following conditions?
  - Seizures (fits):  Yes  No
  - Diabetes (sugar disease):  Yes  No
  - Allergic reactions that interfere with your breathing:  Yes  No
  - Claustrophobia (fear or closed in places)  Yes  No
  - Trouble smelling odors:  Yes  No
- Have you ever had any of the following pulmonary or lung problems?
  - Asbestosis:  Yes  No
  - Asthma:  Yes  No
  - Chronic bronchitis:  Yes  No
  - Emphysema:  Yes  No
  - Pneumonia:  Yes  No
  - Tuberculosis:  Yes  No
  - Silicosis:  Yes  No
  - Pneumothorax (collapsed lung):  Yes  No
  - Lung cancer:  Yes  No
  - Broken ribs:  Yes  No
  - Any chest injuries or surgeries:  Yes  No
  - Any other lung problem that you've been told about:  Yes  No

**MEDICAL QUESTIONNAIRE FOR RESPIRATOR USERS *continued* . . .**

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
  - 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
8. If you've used a respirator, have you ever had any of the following problems?
- If you have never used a respirator, CHECK the following and go directly to Question 9.**  N/A
- 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 speak to the health care professional who will review this questionnaire: Yes No

If you experience any chest pain, shortness of breath, lightheadedness, diaphoresis or anxiety while wearing the PFR- N95 Respirator, remove the respirator IMMEDIATELY and report the symptoms to Employee Health.

**\*\* DO NOT attempt to wear the PFR N-95 mask until your symptoms have been reported and evaluated by Employee Health \*\***

Medically cleared by Employee Health to wear PFR N95 \_\_\_\_\_  
Signature Date