

GENERAL MEDICAL SECTION

YES NO

 140

Are you taking any medication for breathing problems, heart trouble, blood pressure, seizures? (This includes **ALL** prescription drugs, inhalers, patches, etc., even if use is occasional.)

141 - If yes, please list: _____

 142

Are you taking any other prescription or "over the counter" medicines on a daily or regular basis.

143 - If yes, please list: _____

• For each condition with YES response, please note date of diagnosis, current status, and any current treatment. •

 144

Are you currently under a doctor's care for any medical condition?

145 - If yes, please specify condition(s): _____

Have you **ever** had **or** do you **now** have any of the following:

YES NO

(If yes, indicate date of diagnosis, current status and treatment.)

 146

Claustrophobia 147- With respirator use 148- _____

 149

Skin disorders: 150- Eczema 151- Other (Please specify.) _____

 156

Problems with sense of smell/Trouble smelling odors 157- _____

 158

Ear/Hearing problems: 159- Injury 160- Difficulty hearing 161- Hearing aid

162- Ruptured/perforated eardrum (163- resolved, 164- unresolved, 165- unknown)

166- Any other ear/hearing problem (Please specify.) 166.1- _____

 167

Eye/vision problems: 168- Eyeglasses 169- Contact lenses 170- Color blind

171- Lost vision in either eye (172- temporarily 173- permanently)

174- Any other eye or vision problem (Please specify.) 174.1- _____

 175

Musculoskeletal problems 176- Back injury 177- Back pain

178- Weakness in any arm, hand, leg, or foot

179- Pain or stiffness when leaning forward or backward at the waist

180- Difficulty fully moving arms or legs 181- Difficulty fully moving head up or down

182- Difficulty fully moving head side to side 183- Difficulty bending at knees

184- Difficulty squatting to the ground

185- Difficulty climbing a flight of stairs or a ladder while carrying more than 25 lbs.

186- Any other muscle or skeletal problem that interferes with using a respirator:

186.1- _____

 187

Neuromuscular disease 188- Muscular dystrophy 189- Myasthenia gravis

190- ALS (amyotrophic lateral sclerosis/Lou Gehrig's Disease) 191- If yes, describe extent of weakness: _____

 192

Epilepsy/seizure disorder • If yes, enter date of last seizure 193-

and estimated number of seizures per year 194-

Month Year

GENERAL MEDICAL SECTION (cont'd)

YES NO

195 Cancer • 196- If yes, please describe origin, treatment, status: _____
 _____ 197- Lungs affected? Yes No

198 Surgery • 199- Facial 200- Neck 201- Chest 202- Heart 203- Lung
 204- Back 205- Other _____
 206- If yes, indicate date, type and results: _____

RESPIRATORY SECTION

• For each condition with YES response, please note date of diagnosis, current status, and any current treatment. •
 Have you **ever** had **or** do you **now** have any of the following:

YES NO

207 Inhalant allergies (seasonal, animal dander, dusts, etc.) 208- _____
 _____ 209- Interferes with breathing? Yes No

210 All other allergies (including medications, foods, insect bites) 211- _____
 _____ 212- Interferes with breathing? Yes No

213 Abnormal chest x-ray 214- _____

215 Asthma 216- Childhood only 217- Current • 218- If yes, describe onset, last episode
 and frequency: _____

219 Wheezing or asthma-like symptoms 220- Interferes with job 221- On treatment/inhaler
 222- _____

223 Bronchial infections which occur yearly or more frequently 224- _____

225 Bronchitis/Cough 226- Occasional (a.m.) 227- Moderate (4-6 times/day)
 228- Severe (daily over period of 3 mo. or more) 229- Mostly when lying down
 230- _____

231 Sputum/Phlegm with coughing 232- Occasional (a.m.) 233- Moderate (2x/day or 4x/wk)
 234- Severe (daily over period of 3 mo. or more) 235- _____

236 Coughing up blood 237- _____

238 Chest pain when breathing deeply 239- _____

240 Collapsed lung/pneumothorax 241- _____

242 Any chest injuries 243- Broken ribs 244- Other (Please specify.) 245- _____

246 Emphysema 247- _____

248 Silicosis • 249- If yes, please indicate exposure date, diagnosis date and method _____

RESPIRATORY SECTION (cont'd)

YES NO

 250 Pneumonia 251- Remote past only 252- Recent/CurrentIf yes, please indicate approximate date of last episode 253-
Month Year 254

Asbestosis • 255- If yes, please indicate exposure date, diagnosis date and method of diagnosis:

 256 Tuberculosis 257- Positive skin test 258- Treated 259- Untreated

260- _____

 261 Shortness of breath 262- Climbing two flights of stairs 263- Climbing one flight of stairs264- Walking on level ground at ordinary pace 265- Estimated distance in feet 266- Walking on slight incline/hill 267- Walking fast 268- Washing or dressing self269- Interferes with job 270- _____ 271

Any other lung problem you have been told about or other symptoms you think may be related to lung problems? 272- _____

 273 Current symptoms related to workplace only 274- _____ 275 Is HTI, Inc. permitted to inform employer of response to previous question ONLY? 276

Have you had a chest x-ray in the past 6 months? 277- If yes, where? _____

CARDIOVASCULAR SECTION

• For each condition with YES response, please note date of diagnosis, current status, and any current treatment. •
Have you **ever** had **or** do you **now** have any of the following:

YES NO

 278 Chest symptoms Type: 279- Pain 280- Pressure 281- TightnessAge at onset 282- Episode frequency 283- Daily 284- Weekly 285- MonthlyEpisode intensity 286- Mild 287- Moderate 288- SevereEpisode duration 289- Few seconds 290- Few minutes 291- Several minutesAssociated with 292- Activity 293- Interferes with/Associated with jobAccompanied by 294- Sweating 295- Shortness of breath

296- _____

 297 Heartburn or indigestion 298- Acid reflux 299- Ulcer 300- Unrelated to eating

301- _____

 302 Rheumatic heart disease/History of heart murmur 303- Past only 304- Current

305- _____

 306 Irregular heart beat/arrhythmia 307- Heart skipping/missing a beat 308- _____

