LIFE SCAN
Wellness Center

NAME:_____

DEPARTMENT: _____

Dear Life Scan Patient,

Our confidential Wellness Program is designed to provide you with a tool to be proactive with your own health. It is a valuable health and fitness assessment concept that is proven to identify major medical conditions before the onset of catastrophic consequences. It is our experience that heart attacks, strokes, cancer, and other equally devastating diseases can be prevented through early detection! Our early detection program gives you and your family the opportunity for medical intervention before it is too late!

LIFE SCAN WELLNESS PROGRAM

There are three parts to your Life Scan appointment that include Ultrasound Imaging, Physical Exam, and Cardiopulmonary/Fitness Evaluation.

1. **ULTRASOUND:** Life Scan uses ultrasound, an extremely safe way to take "pictures" of arteries and organs. Ultrasound uses sound waves to produce images of the body. Ultrasound does not use any form of radiation. The ultrasound specialists will thoroughly discuss the results of each test with you. The exam will evaluate the different organs for tumors, masses, cysts, enlargements, organ failure, and other critical conditions. The organs include the thyroid, heart, liver, pancreas, gall bladder, spleen, kidneys, bladder, and reproductive organs. The exam will also evaluate overall heart and valve function, efficiency, size, motion, and for potential carotid artery blockages and the aorta for aneurysms.

2. **CARDIOPULMONARY/FITNESS EVALUATION:** Our exercise physiologist will perform a pulmonary function test to assess your lung capacity for respiratory health. This test helps determine if you are able to wear a respirator for job-related duties, it also is critical in the analysis of lung-related health conditions such as asthmas, bronchial conditions, and pulmonary diseases. They will also evaluate your heart activity with a resting electrocardiogram and cardiac stress test. Your functional capacity levels such as muscular strength, endurance, and flexibility and discuss your diet and nutritional habits will then be assessed. They will then propose a personal "Fitness Prescription" based upon your fitness, diet, cardiovascular, and exercise needs.

3. **PHYSICAL EXAM:** The Life Scan comprehensive physical combines the results from the Ultrasound and Cardio-Pulmonary testing to evaluate your total health status. You will receive an extensive "head-to-toe" physical exam that focuses on an in-depth assessment of medical conditions, blood work analysis, blood pressure, vision, and hearing. You will receive education on existing and potential medical problems, health risks, stress factors, diet, and overall recommendations for medical interventions and/or healthy lifestyle changes.

The cornerstone of the Life Scan Wellness Program is based upon the premise that "Knowledge is Power." Understanding your own health and knowing the steps you can take to get healthy and stay healthy will change the course of your health legacy. The Life Scan medical team can give you this knowledge and provide you critical medical advice. However, your health depends on what you do with this knowledge. We encourage you to follow the advice and recommendations of Life Scan's medical team. **Take charge of your own health. Make it your priority…it could save your life!**

Sincerely,

Patricia Johnson

Patricia Johnson
CEO/President
Life Scan Wellness Centers

LIFE SCAN
Wellness Centers

Dear Life Scan Patient,

Welcome to the Life Scan Wellness Program!

In an effort to provide you with the most extensive wellness program to you there are several requirements that must be met prior to your visit.

- **Blood Draws: Must be done at least 5 days prior to your Life Scan appointment**
  - You must bring your Requisition form to the draw station, which is provided in your packet. Fill out Name, Birth Date, Department name in the ID box and Phone Number BEFORE GOING TO THE LABCORP.
  - Any Labcorp Patient Service Center.
  - There is no appointment needed to have your blood drawn at the Labcorp Laboratory.
  - Fasting Required: Minimum 8 hour
    - ✓ You may drink water
    - ✓ Take your medications as normal.
  - Labs will not be reviewed until time of appointment. It is the patients' responsibility to contact Life Scan for results on labs if appointment is missed.

- **Life Scan appointment requirements:**
  - Wear athletic clothes and shoes.
  - Women: Sports bra is recommended.
  - Complete all forms provided in your packet prior to your Life Scan appointment.
  - Please fast for your Life Scan appointment.
    - ✓ If your Life Scan appointment is before 1:00 pm please **DO NOT** eat anything after midnight.
    - ✓ If your Life Scan appointment is after 1:00 pm you may eat a small, light breakfast and any non-carbonated beverage **BEFORE 8:00 am.**
    - ✓ You must have a full urinary bladder in order to visualize certain areas of the body. Please drink 20+ ounces of water at least 45 minutes prior to your appointment time.

- **No Tobacco use 4 hours prior to your Life Scan appointment.**
- **Hazmat Only: No seafood 72 hours prior to your blood draw.**

In order to provide you with the most comprehensive health-assessment program available, we ask that you follow the directions provided in your packet completely. If there is any reason why you cannot complete the indicated requirements, health or otherwise, please notify our staff by phone as soon as possible.

Thank you very much. We look forward to seeing you!

Pamela Desmarais ARNP-BC
Life Scan Wellness Clinical Director

Please read all included material. If you any questions, call our office at
Largo:(727)258-4818 Tampa:(813)876-0625 Jacksonville: (904)646-2105

LIFE SCAN
Wellness Center

Patient Name: _____
Last **First** **Middle Initial**

Patient SS# or Employee ID#: _____

Birth Date: _____ **Age** _____ **Circle One: Male Female**

Employer: _____

Position or Title: _____ **Station or Work Area:** _____

Exam Date: _____

Current Estimated Weight: _____**lbs. Height:** _____**ft.**_____ **in.**

Address: _____

City_____ **State** _____ **ZIP** _____

Contact Phone Number: _____

Alternate Contact Phone Number: _____

Email Address: _____

Can we send you your results via email? Yes___ No ____

Primary Care Physician _____ **Phone** _____

Street Address _____

City_____ **State** _____ **Zip** _____

Physician _____ **Specialty** _____ **Phone** _____

Physician _____ **Specialty** _____ **Phone** _____

Signature _____ ***Date*** _____

LIFE SCAN
Wellness Centers

CONFIDENTIAL HISTORY & HEALTH RISK APPRAISAL

Patient Name_____ **DOB**_____ **Date**_____

Allergies (food, drug etc) _____

Symptoms **Check symptoms you currently have or have had in the past year.**

GENERAL
- ☐ Chills
- ☐ Dizziness
- ☐ Fainting
- ☐ Fevers
- ☐ Forgetfulness
- ☐ Frequent Headaches
- ☐ Weight loss> 10lbs
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Weight gain>10lbs

MUSCLE/JOINT/BONE
Pain, Weakness, Numbness
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs/Knees
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

SKIN
- ☐ Bruise easily
- ☐ Rash/Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Sore that won't heal

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bowel changes
- ☐ Frequent constipation
- ☐ Frequent Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Excessive gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting blood
- ☐ Severe heartburn

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE,THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Sexual Concerns

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in Testicles
- ☐ Penis discharge
- ☐ Sore on penis

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Endometriosis
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Infertility
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ PMS
- ☐ Abnormal Vaginal discharge

Date of last Menstrual period _____

Are you pregnant?_____

Number of Children _____

Other Concerns:

Conditions **you currently have or have had in your lifetime**
- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Anxiety
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Depression
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Neuromyalgia
- ☐ Pacemaker
- ☐ Panic-disorder
- ☐ Pneumonia
- ☐ Polio
- ☐ Polymyalgia
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal Disease
- ☐ Warts

TESTS AND PROCEDURES:

(Please indicate most recent approximate date/year.)

Test	**Approx Date**
☐ Physical Exam	
☐ Dental Exam	
☐ Exercise Stress Test	
☐ Colonoscopy/Flexible Sigmoidoscopy	
☐ Stool Test (for blood)	
☐ Digital Rectal Exam (prostate check) - Male	
☐ Chest X ray	
☐ TB Test	
☐ Mammogram	
☐ Pap Smear -Female	

Do you feel pain in your chest when you do physical activity? ☐ Yes ☐ No (if yes please explain)_____

FAMILY HISTORY

Have parents, siblings, grandparents had any of the following? If adopted and history unknown, check here ____ .

	Yes	No	Relationship		Yes	No	Relationship
Arthritis/Gout				High Blood Pressure			
Asthma				High Cholesterol			
Cancer (type)				Kidney Disease			
Chemical Dependency				Liver Disease			
Diabetes				Mental Illness			
Heart Disease				Tuberculosis			
Heart attack before 55				Other			

If either parent or sibling is deceased, Please list **relationship to you**, **age at death**, and **cause of death**.

Hospitalizations, Surgeries & Major Illness or Injuries (other than normal vaginal childbirth)

Year	Hospital/ Injury/Surgery	Reason for Hospitalization and Outcomes

Women: Number of Pregnancies: ____

Current method of contraception:

Year of Birth:	Gender:	Complications, if any:

Weeks of gestation:

Social History/Health Habits

	Y	N	
Have you ever smoked?			Chew? Yes / No
Number of years you smoked?			Number of years chewed?
Do you currently smoke?			
Number of packs per day			
When did you stop smoking?			
Do you drink beer, hard liquor, or wine?			Number of years

Beer _____**cans**/**ounces**/**glasses** per **day**/**week** (circle which ever applies)

Liquor ____ **cans**/**ounces**/**glasses** per **day**/**week** (circle which ever applies)

Wine _____ **cans**/**ounces**/**glasses** per **day**/**week** (circle which ever applies)

How many times a (Day/Week/Month) do you eat out at
Fast foods? /D/W/M Restaurants? /D/W/M

Do you consume Caffeine beverages?			(specify amount below)
Coffee?			Soda/soft drinks?
Tea? (unsw/sw)			Energy Drinks?
How many oz/glasses/bottles of water do you drink per day?			
Do you exercise?			How often?

Occupational

Occupation:

Numbers of years at current position?

Number of years with current occupation?

Medications (state reason for taking medication)

Vitamins and Supplements

I certify that the above information is correct to the best of my knowledge. I will not hold Life Scan or any members of the Life Scan staff responsible for any errors or omission that I may have made in the completion of this form.

Signature: _____ Date: _____

Reviewed By: _____Date: _____

Health Screening Questionnaire

Name_____ **Age**_____ **Gender M F**

Height_____ **Weight**_____ **Goal weight** _____

Stage 1 - Known Diseases (Medical Conditions)

-List the names of medications you take on a regular basis: _____

-Do you have diabetes?.....No Yes

a) if yes, please indicate if it is insulin-dependent diabetes mellitus (IDDM) or non-insulin-dependent diabetes mellitus (NIDDM)….IDDM NIDDM

b) if IDDM, for how many years have you been on insulin? _____ years

-Have you had a stroke? .....No Yes

-Has your doctor ever said you have heart trouble? .....No Yes

-Do you take asthma medication? .....No Yes

-Are you or do you have reason to believe you may be pregnant? .....No Yes

-Is there any other physical reason that prevents you from participating in an exercise program (e.g. cancer; severe arthritis, kidney or liver disease)? .....No Yes

Stage 2 - Signs and Symptoms

-Do you often have pains in your heart, chest, or surrounding areas, especially during exercise?.....No Yes

-Do you often feel faint or have spells of severe dizziness during exercise? .....No Yes

-Do you experience unusual fatigue or shortness of breath at rest or with mild exertion?.....No Yes

-Have you had an attack of shortness of breath that came on after you stopped exercising? .....No Yes

-Have you been awakened at night by an attack of shortness of breath?.....No Yes

-Do you experience swelling or accumulation of fluid in or around your ankles?.....No Yes

-Do you often get the feeling that your heart is beating faster, racing, or skipping beats, either at rest or during exercise? .....No Yes

-Do you regularly get pains in your calves and lower legs during exercise which are not due to soreness or stiffness?.....No Yes

-Has your doctor ever told you that you have a heart murmur?..... No Yes

Stage 3 - Cardiac Risk Factors

-Do you smoke cigarettes daily, or have you quit smoking within the past two years? No Yes

If yes, how many cigarettes per day (or did you smoke in the past two years)?____/day

-Has your doctor ever told you that you have high blood pressure? ……...No Yes

-Has your father, mother, brother, or sister had a heart attack or suffered from cardiovascular disease before the age of 55?.....No Yes

a) If yes, was the relative male or female?_____

b) At what age did he or she have the stroke or heart attack? _____

c) Did this person die suddenly as a result of the stroke or heart attack?.....No Yes

-Have you experienced menopause before the age of 45?..... ……..... No Yes

If yes, do you take hormone replacement medication?.....No Yes

Stage 4 - Exercise Intentions

Does your job involve sitting for a large part of the day?.....No Yes

What are your current activity patterns?

a) Frequency: _____exercise sessions per week

b) Intensity: Sedentary Moderate Vigorous

c) History: <3 months 3-12 months >12 months

d) Duration: _____minutes per session

What types of exercises do you do?

Do you want to exercise at a moderate intensity (e.g. brisk walking) or at a vigorous intensity? (e.g. jogging)?.....Moderate Vigorous

Typically on regular day I eat:
__Breakfast
__Snack
__Lunch
__Snack
__Dinner
__Snack

Typical **Work Day** diet
_____
_____
_____
_____
_____
_____
_____
_____

Typical **Work Day** drinks
_____
_____
_____

Typical **Off Day** diet
_____
_____
_____
_____
_____
_____
_____
_____

Typical **Off Day** drinks
_____
_____
_____

REVIEWED BY LIFE SCAN EXERCISE PHYSIOLOGIST _____ DATE_____

PATIENT HEALTH QUESTIONNAIRE - PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(circle 0 - 3 to indicate your answer)

	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
ADD COLUMNS				

TOTAL OF ALL COLUMNS
(add all columns) _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
(Circle answer below)

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Reviewed by Nurse Practitioner _____ Date _____

Comments

_____

_____

_____

THE EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to a 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 – 24. The scale estimates whether you are experiencing excessive sleepiness that possible requires medical attention.

How sleepy are you? How likely are you to doze or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. Fore each situation, decide whether or not you would have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the corresponding number for each situation in the column to the right, then total your score.

ACTIVITY	NUMBER
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (ie: theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking with someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

TOTAL SCORE: _____

Analyze Your Score

Interpretation:

0 - 7: it is unlikely that you are abnormally sleepy
8 - 9: you have an average amount of daytime sleepiness
10 – 15: you may be excessively sleepy depending on the situation and may want to consider seeking medical attention
16 - 24 : you are excessively sleepy and you should follow up with your PCP

References: Johns, MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep* 1991; 14(6):540-5.

This is a modified format of the Epworth Sleepiness Scale provided as a courtesy by Talk About Sleep, Inc www.talkaboutsleep.com

ALL PARTICIPANTS

Please read the following questions and answer them honestly.

YES	NO		
☐	☐	1.	Has your doctor ever said that you have a heart condition AND that you should only do physical activity recommended by a doctor?
☐	☐	2.	Do you feel pain in your chest when you do physical activity?
☐	☐	3.	In the past month, have you had chest pain when you were not doing physical activity?
☐	☐	4.	Do you lose your balance because of dizziness or do you ever lose consciousness?
☐	☐	5.	Is your doctor currently prescribing medications for your blood pressure or a heart condition?
☐	☐	6.	Do you know of any other reason why you should not do physical activity?

I have read the above questions and have no known contraindications to exercising. I understand that I will be completing a physical fitness evaluation and submaximal stress test today as part of my exam.

Date: _____

Department: _____

Patient Name: _____/_____
PRINT NAME **SIGNATURE**

Exercise Physiologist: _____/_____
PRINT NAME **SIGNATURE**

Nurse Practitioner: _____/_____
PRINT NAME **SIGNATURE**

Back Health History

Name: _____ **Date:**_____

PLEASE ANSWER THE FOLLOWING QUESTIONS (IF YES, GIVE DATES & EXPLANATION)

Back Health History

□ **Yes** □ **No** Are you pregnant? If Yes, EDD: _____ Last Menstrual Period: _____

□ **Yes** □ **No** Degenerative Joint Disease? Date(s): _____ Explain: _____

□ **Yes** □ **No** Fractures? Date(s): _____ Explain: _____

□ **Yes** □ **No** Mobility Limitations? Date(s): _____ Explain: _____

□ **Yes** □ **No** Osteoarthritis? Date(s): _____ Explain: _____

□ **Yes** □ **No** Do you wake up stiff? Date(s): _____ Explain: _____

□ **Yes** □ **No** Do you exercise regularly? What Kind: _____

Back Injuries

□ **Yes** □ **No** Have you had back injuries? Explain: _____

□ **Yes** □ **No** Was it a workers' compensation? Explain: _____

□ **Yes** □ **No** Was hospitalization required? Explain: _____

□ **Yes** □ **No** Was surgery required? Explain: _____

□ **Yes** □ **No** Did it result in lost work? Explain: _____

What relieved your pain following this injury? □ **Medication** □ **Physical Therapy** □ **Other**

Explain: _____

_____

What was the location of the pain? □ **Back and Hips** □ **Radiated to Legs** □ **Radiated to Arms**

Explain: _____

□ **Yes** □ **No** Have you ever had a medical condition that resulted in an impairment rating or permanent restriction?

Explain: _____

I certify that the above information is true and complete to the best of my knowledge and grant the personnel/HR department to verify such answers. I understand that any false statement may be considered as sufficient cause for rejection or dismissal if such statement is discovered subsequent to my employment.

Signature _____ Date _____

Life Scan Office Use Only- DO NOT WRITE BELOW THIS LINE

Back Health History

Exercise

BOUNCE TEST

Have patient lean over and bounce to touch toes several times

□ Yes □ No Grimace or other signs of pain

□ Yes □ No Hamstring tightness (unable to reach to at least mid-calf region)

□ Yes □ No Unable to stand up or pushes on knees to stand up

MUSCLE STRENGTH (LYING ON MAT)

□ Yes □ No Weakness in arms (push me, pull me is unequal)

□ Yes □ No Weak abdominals (unable to do 5 sit ups with knees bent)

□ Yes □ No Weak back extensors (unable to raise straight arms and legs when on stomach)

BODY MECHANICS

□ Yes □ No Able to lift and carry 30lbs minimum, or company specified ____ lbs

MUSCLE FLEXIBILITY (LYING ON MAT)

□ Yes □ No Knee-to-Chest (unable to bring both knees to chest easily)

□ Yes □ No Positive straight leg raise (lying flat, legs extended, unable to raise legs at least 75 degrees)

Physical Exam

POSTURAL EVALUATION □ All Normal

□ Kyphosis (round back)

□ Leg Length discrepancy (check iliac crests)

□ Lordosis (sway back)

□ Obesity

□ Scoliosis (check shoulder level, palpate spinous processes)

GAIT ANALYSIS □ All Normal

□ Abnormal Gait pattern (shuffles, drags toes, uneven steps, etc.)

□ Unable to semi-squat for several seconds

□ Unable to stand on one leg (other hip drops, leans over to maintain balance)

□ Unable to walk on heels (holds toes on one foot higher than the other)

□ Unable to walk on toes (rises higher on one foot than the other)

Initials of Exercise Physiologist Completing Exercises:_____ Comments:_____

Life Scan Practitioner: _____ Date: _____

LIFE SCAN
Wellness Centers

OSHA Respirator Medical Evaluation Questionnaire

(Mandatory). –1910.134 App C

This form is for OSHA respirator clearance. All employees must fill this form out completely and bring it to your Life Scan appointment. If you use a SCBA you must also fill you the additional information as stated.

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

To the employee:

Can you read (circle 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.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:_____

2. Your name:_____ID#_____

3. Your age (to nearest year):_____

4. Sex (circle one): Male/Female

5. Your height: _____ ft. _____ in.

6. Your weight: _____ lbs.

7. Your job title:_____

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____

9. The best time to phone you at this number: _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

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

a. _____ N, R, or P disposable respirator (filter-mask, non- cartridge type only).

b. _____ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): Yes/No

If "yes," what type(s):_____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

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): 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. Atrial Fibrillation, Supraventricular Tachycardia or Ventricular Tachycardia: Yes/No
g. Cardiac Arrest: Yes/No
h. High blood pressure: Yes/No
i. 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'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 health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). <u>For employees who have been selected to use other types of respirators, answering these questions is voluntary</u>.

10. Have you **ever-lost** vision in either eye (temporarily or permanently): Yes/No

11. Do you **currently** have any of the following vision problems?

    a. Wear contact lenses: Yes/No
    b. Wear glasses: Yes/No
    c. Color blind: Yes/No
    d. Any other eye or vision problem: Yes/No

12. Have you **ever had** an injury to your ears, including a broken eardrum: Yes/No

13. Do you **currently** have any of the following hearing problems?

    a. Difficulty hearing: Yes/No
    b. Wear a hearing aid: Yes/No
    c. Any other hearing or ear problem: Yes/No

14. Have you **ever had** a back injury: Yes/No

15. 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 fully moving your arms and legs: Yes/No
    d. Pain or stiffness when you lean forward or backward at the waist: Yes/No
    e. Difficulty fully moving your head up or down: Yes/No
    f. Difficulty fully 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 interferes with using a respirator: Yes/No