Kaiser On-the-Job®

IMPRINT AREA

FIREFIGHTER PREPLACEMENT AND
PERIODIC HEALTH HISTORY QUESTIONNAIRE

Name: ______________________________ Sex: ☐ Male ☐ Female Date of Birth___________

Home Address: ____________________________________ City ______________ Zip__________

Home Telephone: __________ Fax: _________ Company: ___________ Phone/Fax:_____________

Social Security # __________Job Title: _______________Department:________ Hire Date:_______

INTRODUCTION:
The information you provide in this questionnaire is extremely important. It will be used by a physician or health care professional to advise your employer of your ability to perform the essential functions of the job safely without endangering yourself or others. Please fill out the questionnaire completely and accurately.

Please answer all questions completely. Do not leave any answers blank; use either "NA" (not applicable) or "Don't Know."

1. List your last 3 hospitalizations (**excluding routine childbirth**):

Date	Age	Condition	Name of Hospital, City & State

2. List any other operations or surgeries not included above:

Date	Age	Condition	Name of Hospital, City & State

3. Date of Last Tetanus Immunization ______________________(Never) (Unknown)

4. List all medications (prescription and non-prescription) that you are currently taking (including vitamins, aspirin, antihistamines, cold medications, reducing aids, recreational drugs, etc.):

____
____
____
____

5. List all medications (prescription and non-prescription) not listed above that you have taken in the past two months____
____
____

6. Do you have, or have you ever had (check all that apply - circle those you don't know):

__ Vision problems -eye disease, surgeries, temporary/permanent loss of vision in either eye
__ Skin condition (recurrent eczema, irritated skin, open lesions)
__ Dizziness/fainting/loss of consciousness
__ Psychological problems/stress/depression
__ Prior drug/alcohol treatment
__ Asthma/Chronic Bronchitis/Emphysema
__ Bad reaction to cold, heat, heights or closed spaces
__ Thyroid problems
__ Chest pain or heart problems
__ Fractures (broken bones or ribs)
__ Diabetes
__ Ulcer/Irritable Bowel/Crohns Disease
__ Cancer, leukemia, or compromised immune system
__ Convulsions/seizures/epilepsy
__ Headaches
__ Chronic Fatigue/Gulf War Syndrome
__ Tuberculosis
__ Pneumothorax
__ Swollen ankles or varicose veins
__ Bleeding tendency
__ Trouble Smelling odors
__ Hepatitis
__ Hernia
__ Anemia
__ Chronic or recurring pain or limited motion associated with:

__ Neck	__ Wrist	__ Back	__ Ankle
__ Shoulder	__ Hand	__ Hip	__ Foot
__ Elbow	__ Knee		

Please Circle One --- "NO" "YES" "?"

7. Do you currently use tobacco or have you used it in the last month? YES NO ?

8. Are you currently taking any drugs or illegal substances not authorized by your physician or health care professional for medical purposes? YES NO ?

9. Have you ever had a reaction, allergy, and/or sensitivity to any drugs (such as codeine, penicillin, or sulfa), latex, foods, plants, or chemicals? YES NO ?

10. Have you ever had an allergic reaction that affected your breathing? YES NO ?

Describe ____

11. 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 ?
Describe____

12. Have you ever had any of the following cardiovascular or heart problems?

a. High blood pressure? YES NO ?
b. Elevated Cholesterol YES NO ?
c. Heart Murmur YES NO ?
d. Stroke? YES NO ?
e. Angina? YES NO ?
f. Heart failure? YES NO ?
g. Swelling in your legs or feet (not caused by walking) YES NO ?
h. Heart arrhythmia (heart beating irregularly)? YES NO ?
i. Heart attack? YES NO ?
j. Any other heart problem that you've been told about? YES NO ?
Describe ____

13. 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 ?
Describe____

14. If you've used a respirator, have you ever had any of the following problems?

a. Eye irritation? YES NO ?
b. Skin allergies or rashes? YES NO ?
c. Anxiety or Claustrophobia? YES NO ?
d. General weakness or fatigue? YES NO ?
e. Any other problem that interferes with your use of a respirator? YES NO ?
Describe____

15. Are you currently under medical care for any emotional or physical illnesses? YES NO ?

16. Have you been advised to have any operations which have not yet been done? YES NO ?

17. Have you ever had an injury at work or home that required restricted activity? YES NO ?

18. Do you currently have a workers’ compensation or disability claim pending or open? YES NO ?

19. Are you currently receiving any medical disability payments (SDI, VA, LTD, SSI, etc.)? YES NO ?

20. Have you ever changed jobs or work assignments because of any health problems or injuries? YES NO ?

21. Have you ever had a physician or health care professional give you activity restrictions? YES NO ?

If so, are you back on full duty? YES NO ?

If no, describe____

22. Have you ever been unable to work because of any back/neck/joint problems? YES NO ?

23. Have you had menstrual problems that kept you off work? YES NO ?

24. Do you take medications at work or before work which you believe could affect your physical or mental function or performance? YES NO ?

25. Have you ever been unable to hold a job or refused employment because of any physical, mental, or other health related reason? YES NO ?

26. Have you ever been rejected or discharged from a military position because of any physical, mental, or other health related reason? YES NO ?

27. Within the past year, have you had repeated feelings of numbness, tingling, or "pins and needles" sensations in one or both hands? YES NO ?

28. Within the past year, have you had repeated feelings of soreness or pain in either forearm or elbow? YES NO ?

29. Have any of the above symptoms (numbness, tingling, soreness or pain) caused you to be awakened while sleeping? YES NO ?

30. Does discomfort in your wrist, arm or shoulder interfere with your daily activities (eating, writing, sports, etc.) YES NO ?

31. 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 ?

32. Have you ever had an injury to your ears, including a broken eardrum? YES NO ?

33. 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 ?

34. 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 moving your head side to side? YES NO ?

g. Difficulty bending at your knees? YES NO ?

h. Difficulty squatting to the ground? YES NO ?

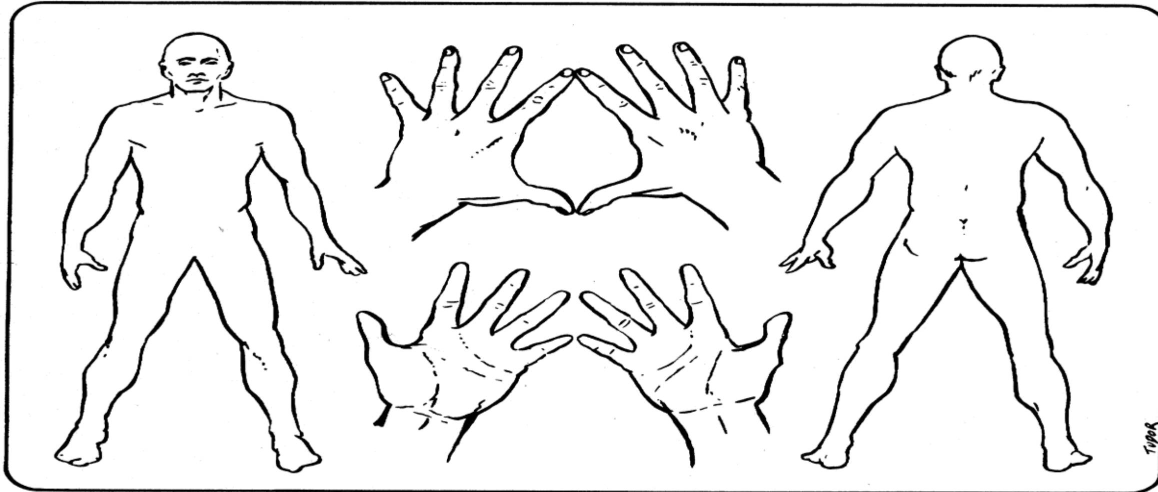
i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs? YES NO ?

j. Any other muscle or skeletal problem that interferes with using a respirator? YES NO ?

37. Have you ever received medical treatment for the pain and/or discomfort noted above? YES NO ?

38. Please mark on the diagrams below where, in the past year, you have had:

PAIN == xxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx TINGLING or NUMBNESS == •••••••••••••••••• ••••••••••••••••••



39. Have you ever or are you currently being followed for any hazardous or toxic (biological, post-exposure chemical, physical)? YES NO ?

40. Have you had any chemical or biological exposures since your last examination that you know of and/or have concerns? YES NO ?

41. Relative to this job, is there any health-related condition for which you require accommodation (i.e. job modification or structural changes in work area)? YES NO ?
If so, please list: ____

42. How much exercise (outside of work) do you get in a typical week? Please explain.

____

I hereby certify that all of my statements and answers are true and complete, and I understand that any misstatement of material fact may subject me to disqualification or dismissal and may cause forfeiture of all rights to employment.

Signature in full: ______________________ Date: ______________

Reviewer: ______________________ Date: ______________

Clinician Comments: ____

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