

**Winona Fire Department
Respiratory Medical Evaluation**

Per 1910.134 Appendix C

Name	Job Title	
Age	Height	Weight
Date	Sex	
Telephone	Best Time to Call	

		Yes	No
1.	Has the Winona Fire Department told you how to contact the health care professional who will review this questionnaire?		
2.	The Winona Fire Department uses self-contained breathing apparatus (SCBA). Have you worn one in the past?		
3.	Do you <i>currently</i> smoke tobacco, or have you smoked in the last month?		
4.	Have you <i>ever</i> had any of the following conditions:		
	Seizures (fits)		
	Diabetes (sugar disease)		
	Allergic reactions that interface with your breathing		
	Claustrophobia		
	Trouble smelling odors		
5.	Have you <i>ever</i> had any of the following pulmonary or lung problems:		
	Asbestosis		
	Asthma		
	Chronic Bronchitis		
	Emphysema		
	Pneumonia		
	Tuberculosis		
	Silicosis		
	Pneumothorax (collapsed lung)		
	Lung cancer		
	Broken ribs		
	Any chest injuries or surgeries		
	Any other lung problem that you've been told about		
6.	Do you <i>currently</i> have any of the following symptoms of pulmonary or lung illness:		
	Shortness of breath		
	Shortness of breath when walking fast on level ground or walking up a slight hill or incline		
	Shortness of breath when walking with other people at an ordinary pace on level ground		
	Have to stop for breath when walking at your own pace on level ground		
	Shortness of breath when washing or dressing yourself		
	Shortness of breath that interferes with your job		
	Coughing that produces phlegm (thick sputum)		

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	Coughing that wakes you early in the morning		
	Coughing that occurs mostly when you are lying down		
	Coughing up blood in the last month		
	Wheezing		
	Wheezing that interferes with your job		
	Chest pain when you breathe deeply		
	Any other symptoms that you think may be related to lung problems		
7.	Have you <i>ever</i> had any of the following cardiovascular or heart problems:		
	Heart attack		
	Stroke		
	Angina		
	Heart failure		
	Swelling on your legs or feet (not caused by walking)		
	Heart arrhythmia (heart beating irregularly)		
	High blood pressure		
	Any other heart problem that you've been told about		
8.	Have you <i>ever</i> had any of the following cardiovascular or heart symptoms:		
	Frequent pain or tightness in your chest		
	Pain or tightness in your chest during physical activity		
	Pain or tightness in your chest that interferes with your job		
	In the past two years, have you noticed your heart skipping or missing a beat		
	Heartburn or indigestion that is not related to eating		
	Any other symptom that you think may be related to heart or circulation problems		
9.	Do you <i>currently</i> take medication for any of the following problems:		
	Breathing or lung problems		
	Heart trouble		
	Blood Pressure		
	Seizures (fits)		
10.	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 11):		
	Eye irritation		
	Skin allergies or rashes		
	Anxiety		
	General weakness or fatigue		
	Any other problem that interferes with your use of a respirator		
11.	Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?		
12.	Have you <i>ever</i> lost vision in either eye (temporarily or permanently)?		
13.	Do you <i>currently</i> have any of the following vision problems:		
	Wear contact lenses		
	Wear glasses		
	Color blind		
	Any other eye or vision problem		
14.	Have you <i>ever</i> had an injury to your ears, including a broken ear drum?		
15.	Do you <i>currently</i> have any of the following hearing problems:		

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	Difficulty hearing		
	Wear a hearing aid		
	Any other hearing or ear problem		
16.	Have you ever <i>had</i> a back injury?		
17.	Do you <i>currently</i> have any of the following musculoskeletal problems:		
	Weakness in any of your arms, hands legs, or feet		
	Back pain		
	Difficulty fully moving your arms and legs		
	Pain or stiffness when you lean forward or backward at the waist		
	Difficulty fully moving your head up or down		
	Difficulty fully moving your head side to side		
	Difficulty bending at your knees		
	Difficulty squatting to the ground		
	Climbing a flight of stairs or a ladder carrying more than 25 pounds		
	Any other muscle or skeletal problem that interferes with using a respirator		
18.	Any other conditions that you feel effect the same use of self-contained breathing apparatus?		
	Examining physician's general comments:		

Based on the results of the aforementioned physical examination, I certify that this individual is capable of wearing a self-contained breathing apparatus.

Physician's Signature

Employee Signature