Mt. San Antonio College
Fire Technology Program
1100 N. Grand Ave., Walnut, CA 91789 -- (909) 274-5193

Confidential Respirator Medical Questionnaire

The Fire Technology Program requires that the following information be provided by every student who has been selected to use a self-contained breathing apparatus (SCBA).

Date: _____ Name: _____ Male Female

Phone: _____ Height: _____ ft. _____ in. Weight: _____ lbs. Age: _____ DOB: _____

Please answer **YES** or **NO** to every question.

1. Have you ever worn a respirator?
   If yes, what type:
   _____
   ❑ Yes ❑ No

2. Do you **currently** smoke tobacco or have you smoked tobacco in the last month?
   ❑ Yes ❑ No

3. Have you **ever had** any of the following conditions?
   a. Seizures ❑ Yes ❑ No
   b. Claustrophobia ❑ Yes ❑ No
   c. Diabetes ❑ Yes ❑ No
   d. Trouble smelling odors ❑ Yes ❑ No
   e. Allergic reactions that interfere with breathing ❑ Yes ❑ No

4. Have you **ever had** any of the following pulmonary problems?
   a. Asbestosis ❑ Yes ❑ No
   b. Emphysema ❑ Yes ❑ No
   c. Silicosis ❑ Yes ❑ No
   d. Lung cancer ❑ Yes ❑ No
   e. Asthma ❑ Yes ❑ No
   f. Pneumonia ❑ Yes ❑ No
   g. Tuberculosis ❑ Yes ❑ No
   h. Broken ribs ❑ Yes ❑ No
   i. Chronic bronchitis ❑ Yes ❑ No
   j. Pneumothorax (collapsed lung) ❑ Yes ❑ No
   k. Any chest injuries or surgeries: ❑ Yes ❑ No
      _____ ❑ Yes ❑ No
   l. Any other lung problem: ❑ Yes ❑ No
      _____

5. Do you **currently** have any of the following pulmonary symptoms?

a. Shortness of breath	❑ Yes	❑ No
b. Wheezing	❑ Yes	❑ No
c. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	❑ Yes	❑ No
d. Shortness of breath when walking with other people at an ordinary pace on level ground	❑ Yes	❑ No
e. Have to stop for breath when walking at your own pace on level ground	❑ Yes	❑ No
f. Shortness of breath that interferes with your activities	❑ 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 when you are lying down	❑ Yes	❑ No
j. Coughing up blood in the last month	❑ Yes	❑ No
k. Chest pain when you breathe deeply	❑ Yes	❑ No
l. Wheezing that interferes with your activities	❑ Yes	❑ No
m. Any other symptoms that you think may be related to lung problems: _____	❑ Yes	❑ No

6. Do you **currently** have any of the following cardiovascular symptoms or conditions?

a. Heart attack	❑ Yes	❑ No
b. Angina	❑ Yes	❑ No
c. Heart failure	❑ Yes	❑ No
d. Stroke	❑ Yes	❑ No
e. Swelling in your legs or feet (not caused by walking)	❑ Yes	❑ No
f. Heart arrhythmia (irregular heart beat)	❑ Yes	❑ No
g. High blood pressure	❑ Yes	❑ No
h. Any other heart problems: _____	❑ Yes	❑ No

7. Have you **ever had** any of the following cardiovascular 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 activities	❑ 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

8. Do you currently take any medication for any of the following problems?
    a. Breathing or lung problems ❑ Yes ❑ No
    b. Blood pressure ❑ Yes ❑ No
    c. Heart problems ❑ Yes ❑ No
    d. Seizures ❑ Yes ❑ No

9. If you've ever 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. General weakness or fatigue ❑ Yes ❑ No
    d. Anxiety ❑ Yes ❑ No
    e. Any other problem that interferes with your use of a respirator ❑ Yes ❑ No

10. Have you ***ever*** lost vision in either eye (permanently or temporary)? ❑ Yes ❑ No

11. Do you ***currently*** have any of the following vision problems?
    a. Must wear contact lenses ❑ Yes ❑ No
    b. Must wear eye 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 ear drum? ❑ Yes ❑ No

13. Do you ***currently*** have any of the following hearing problems?
    a. Difficulty hearing ❑ Yes ❑ No
    b. Wear hearing aids ❑ Yes ❑ No
    c. Any other ear or hearing 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 moving your arms or legs ❑ Yes ❑ No
    d. Pain or stiffness when bending forward or backward ❑ Yes ❑ No
       at hour waist ❑ Yes ❑ No
    e. Difficulty fully moving your head up and 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 ladder carrying more than 25 pounds of weight ❑ Yes ❑ No
    j. Any other muscle or skeletal problem ❑ Yes ❑ No

16. When you are at altitudes > 5000 feet or in other environments that have lower than normal amounts of oxygen, do you ever have feelings of:
    a. Dizziness ❑ Yes ❑ No
    b. Shortness of breath ❑ Yes ❑ No
    c. Pounding in your chest ❑ Yes ❑ No

17. At work or at home, have you ever been exposed to:
    a. Hazardous solvents ❑ Yes ❑ No
    b. Hazardous airborne chemicals (***e.g.,*** gases, fumes, dust) ❑ Yes ❑ No
    c. Hazardous chemicals through skin contact ❑ Yes ❑ No

    If "yes", provide the names of the chemicals if known:

    _____

18. Have you ever worked with any of the materials, or under any conditions, listed below?

a.	Asbestos	❑ Yes	❑ No
b.	Silica (e.g., in sandblasting)	❑ Yes	❑ No
c.	Cobalt (grinding or welding)	❑ Yes	❑ No
d.	Beryllium	❑ Yes	❑ No
e.	Aluminum	❑ Yes	❑ No
f.	Coal (mining)	❑ Yes	❑ No
g.	Iron	❑ Yes	❑ No
h.	Tin	❑ Yes	❑ No
i.	Dusty environments	❑ Yes	❑ No
j.	Any other exposures	❑ Yes	❑ No

If "yes", describe your exposures:

_____
_____
_____
_____
_____

19. List any jobs or side business you have:

_____
_____

20. List your previous occupation(s):

_____
_____

21. List your current hobbies and previous hobbies:

_____
_____
_____

22. Have you ever been in the military? ❑ Yes ❑ No
If "yes", were you exposed to biological or chemical agents in training or combat?

23. Have you ever worked on a HAZMAT team? ❑ Yes ❑ No

24. Other than medications for breathing and pulmonary problems, heart problems, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason, including over-the-counter medications? ❑ Yes ❑ No

Additional Medical Considerations

1. You will **not** be using any of the following items with your respirators:
    a. HEPA filters
    b. Canisters (***e.g.,*** gas masks)
    c. Cartridges

2. You will be expected to use the respirator for less than 2 hours per day.

3. During the period you are using the respirator, you will have a **heavy work effort** (above 350 kcal/hour), lasting for a period of 2 hours average. Examples of heavy work effort include:
    a. Lifting a heavy load (50 pounds) from the floor to your waist or shoulder
    b. Walking up a 8 degree grade about 2 mph
    c. Climbing stairs with a heavy load (50 pounds)
    d. Shoveling

4. You will be wearing protective clothing and/or equipment when using your respirator, including:
    a. Safety vest
    b. Structure jacket
    c. Structure pants
    d. Structure boots
    e. Structure gloves
    f. Structure helmet
    g. Structure hood

5. You will be working under cold conditions < 0 degrees Fahrenheit or hot conditions > 90 degrees Fahrenheit.

6. You will be working under dry or humid conditions (<30% RH or >70% RH).

7. You will be participating in:
    a. Structure fire fighting
    b. Extrication
    c. Equipment movement
    d. Self-contained breathing apparatus (SCBA) training
    e. Live fire exercises

8. You will be encountering special hazardous conditions when using the respirator, including:
    a. Confined spaces
    b. Life-threatening gases
    c. Smoke

I affirm that the information listed above is true and accurate to the best of my knowledge.

_____ _____

Patient Signature ***Date***