heartfitforduty.org

Protecting Our First Responders

Date: _____

Personal Information		
Last Name:	First Name:	M.I.
Address:		
City:	State:	Zip:
Phone:	D.O.B.	Age:
Gender: ☐ M ☐ F	Email:	

Employer Information	
Employer:	Hire Date:
Employment Status (FT, PT, Volunteer):	Employer Phone:
Employee ID #:	Rank/ Title:

Emergency Notification Contact Information		
Name:		
Relationship:		
Contact Phone 1:	Contact Phone 2:	
Address:		
City:	State:	Zip:

Primary Care Physician Information		
Primary Care Physician or Group:		
Phone:	Fax:	
Office Address:		
City:	State:	Zip:

HeartFit For Duty
1901 E University Drive,
Ste #240, Mesa Az. 85203

Phone: 480-828-5866
Fax: 855-600-2904
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Patient Name:_____

1. Would you like to talk to the healthcare professional who will review this questionnaire, about your answers to this questionnaire: ☐ Yes ☐ No
2. A phone number where you can be reached by the healthcare professional, who reviews the questionnaire (Please include the area code): _____
3. The best time to reach you at this number: _____
4. Do you currentlysmoke tobacco, or have you smoked tobacco in the last month: ☐ Yes ☐ No
5. Have you ever hadany of the following conditions?
   a. Seizures: ☐ 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
6. Have you ever hadany 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

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Patient Name:_____

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

7. Do you currentlyhave 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

8. Have you ever hadany of the following cardiovascular or heart problems?

a. Heart attack: ☐ Yes ☐ No

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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. Heart arrhythmia (heart beating irregularly): ☐ Yes ☐ No

g. High blood pressure: ☐ Yes ☐ No

h. Any other heart problem that you've been told about: ☐ Yes ☐ No

9. Have you ever hadany 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

10. Do you currentlytake 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: ☐ Yes ☐ No

11. If you've used a respirator, have you ever hadany of the following problems? (If you've never used a respirator, check the following space and go to question 9)

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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

Questions 9 to 14 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

12. Have you ever lostvision in either eye (temporarily or permanently): ☐ Yes ☐ No

13. Do you currentlyhave 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

14. Have you ever had an injury to your ears, including a broken ear drum: ☐ Yes ☐ No

15. 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

16. Have you ever hada back injury: ☐ Yes ☐ No

17. Do you currentlyhave any of the following musculoskeletal problems?

    a. Weakness in any of your arms, hands, legs, or feet: ☐ Yes ☐ No

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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

18. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals:

☐ Yes ☐ No

a. If "yes," name the chemicals if you know them: _____

_____

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

a. Asbestos: ☐ Yes ☐ No

b. Silica (e.g, in sandblasting): ☐ Yes ☐ No

c. Tungsten/cobalt (e.g., grinding or welding this material): ☐ Yes ☐ No

d. Beryllium: ☐ Yes ☐ No

e. Aluminum: ☐ Yes ☐ No

f. Coal (for example, mining): ☐ Yes ☐ No

g. Iron: ☐ Yes ☐ No

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h. Tin: ☐ Yes ☐ No

i. Dusty environments: ☐ Yes ☐ No

j. Any other hazardous exposures: ☐ Yes ☐ No

i. If "yes" answered to any of the above, describe the exposure(s):

_____

_____

20. List any second jobs or side businesses you have: _____

_____

21. List your previous occupations: _____

_____

22. List your current and previous hobbies: _____

_____

23. Have you been in the military services? ☐ Yes ☐ No

a. If "yes," were you exposed to biological or chemical agents (either in training or combat):

☐ Yes ☐ No

24. Have you ever worked on a HAZMAT team? ☐ Yes ☐ No

25. Alcohol Use: ☐ Yes ☐ No

a. How many beers do you drink each week? _____

b. How many bottles of wine per week? _____

c. How many drinks of liquor per week? _____

26. Tobacco Current Use:

a. Do you currently use tobacco? ☐ Yes ☐ No

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b. How many of the following do you smoke or chew per day?

i. Cigarettes _____ Packs/day x _____years

ii. Chew _____ Cans/day x _____years

27. Tobacco Past Use: ☐ Yes ☐ No

a. Have you used tobacco in the past? ☐ Yes ☐ No

b. How many of the following do you smoke or chew per day?

i. Cigarettes _____ Packs/day x _____years

ii. Chew _____ Cans/day x _____years

iii. Quit Date: _____

28. Fitness Review:

a. Please list your exercise activities and number of times per week you perform each.

i. Aerobic _____x week

ii. Weight Training _____x week

iii. Other: _____

b. Since your last exam, compare your activity level: ☐ More ☐ Less ☐ Same

29. Occupational Exposures: ☐ Yes ☐ No

a. Have you had any work related exposures to fires or HazMat situations where you have developed health changes? ☐ Yes ☐ No

i. If yes, please describe:_____

b. Other Work Related Health Problems (since last exam)

i. Occupational Injuries/Illnesses: _____

ii. Diagnosis: _____Time Lost:_____

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c. Are you a member of the Hazardous Materials Team? ☐ Yes ☐ No

   i. If yes, have you had any exposures in the last year? ☐ Yes ☐ No

d. Are you a member of the FEMA (AZ Task Force-1) team? ☐ Yes ☐ No

   i. If yes, have you been on a deployment in the last year? ☐ Yes ☐ No

30. Recreational / Hobbies Review: ☐ Yes ☐ No

a. Are you finding your hobbies and recreation less enjoyable? ☐ Yes ☐ No

b. Do you feel fatigued even if you have not been physically active? ☐ Yes ☐ No

c. Are you worrying more than usual? ☐ Yes ☐ No

d. Are you more irritable than usual around family or co-workers? ☐ Yes ☐ No

e. List your hobbies (i.e. woodworking, stained glass, etc.) and number of times per week you perform them:

   i. _____x week _____

   ii. _____x week _____

   iii. _____ x week _____

   iv. _____x week _____

f. Do you use any chemicals or other materials in your hobbies such as solvents, solder, pesticides, lead, or other materials? ☐ Yes ☐ No

g. If yes, please describe chemicals involved:_____

31. Medication Review:

a. Are you currently taking, or have you taken any of the following within the past month?

☐ Antacids	☐ Blood pressure pills	☐ Sleeping pills
☐ Antibiotics	☐ Codeine	☐ Testosterone/Anabolic Steroid
☐ Anticoagulants (blood thinners)	☐ Cortisone or Steroids	☐ Thyroid
☐ Antidepressants	☐ Digitalis	☐ Tranquilizers

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- ☐ Antihistamines
- ☐ Anti-inflammatory
- ☐ Appetite suppressants
- ☐ Aspirin
- ☐ Diuretic (water pills)
- ☐ Hormones
- ☐ Insulin/oral diabetic drug
- ☐ Laxatives
- ☐ Tylenol
- ☐ Vitamins/Supplements

b. List any drugs (by name) you take regularly and the dosage used:

_____

_____

32. Since your last exam, have you developed any allergies? ☐ Yes ☐ No

a. If yes, please describe _____

33. Since your last exam, have you had any difficulties having children? (i.e. infertility, miscarriage, spontaneous abortion) ☐ Yes ☐ No ☐ N/A

a. If yes, please describe: _____

34. Since your last exam, have you had any health changes or problems? ☐ Yes ☐ No

a. If yes, please describe:

_____

_____

35. Since your last exam, have you been hospitalized? ☐ Yes ☐ No

a. If yes, please describe:_____

36. Since your last exam, have you had any surgery(s)? ☐ Yes ☐ No

a. If yes, please describe (give dates and reasons):

_____

_____

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