



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:

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HeartFit For Duty
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HEARTFITFORDUTY.ORG

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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 currently smoke tobacco, or have you smoked tobacco in the last month: Yes No

5. Have you ever had any 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 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

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- 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 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
8. Have you ever had any 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 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

10. 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: Yes No

11. 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)



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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 lost vision in either eye (temporarily or permanently): Yes No
- 13. 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
- 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 had a back injury: Yes No
- 17. Do you currently have 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):

