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Your Health And Safety Source

PATIENT NAME_____ **DATE** _____

PATIENT ADDRESS_____ **CITY**_____ **ZIP CODE**_____

DOB_____ **PHONE**_____

EMPLOYER NAME_____

MEDICAL SURVEILLANCE

19A PHYSICAL
DOT PHYSICAL
FIRE DEPT PHYSICAL
PHYSICAL
POLICE/ROAD PATROL PHYSICAL
MASK FIT/CLEARANCE
RESPIRATOR WRITTEN OPINION
SCBA FIT TEST
AUDIOGRAM
PFT
EKG
VISUAL ACUITY
PULSE OXIMETRY
ASBESTOS
HAZMAT

TESTING

BLOOD COLLECTION
HAIR/FINGERNAIL
BREATH ETOH
DOT/NIDA COLLECT & TEST
SAP5 COLLECT & TEST
SAP 10 COLLECT & TEST

IMMUNIZATIONS

TETANUS
PPD
HEP B #_____
HEP A
MMR
FLU/PNEUMONIA

LABORATORY

CBC
CHOLESTEROL
HEPATITIS SCREEN
HIV SCREEN
LIPID PANEL
MMR TITER
GLUCOMETER FINGER STICK
HEP B TITER
ZPP
SERUM LEAD
CHEST X RAY 1 VIEW/2 VIEW
URINALYSIS
PSA
OTHER _____

WORKERS COMPENSATION

NEW PATIENT

99201 E/M LEVEL 1
99202 E/M LEVEL 2
99203 E/M LEVEL 3
99204 E/M LEVEL 4
99205 E/M LEVEL5

ESTABLISHED PATIENT

99211 E/M LEVEL 1
99212 E/M LEVEL 2
99213 E/M LEVEL 3
99214 E/M LEVEL 4
99215 E/M LEVEL 5

DIAGNOSIS

INTERNAL NOTES:_____

_____

_____

_____

_____

_____

_____

SIGNATURE – MEDICAL PROVIDER

EASTERN MED, LLC
5010 STATE HWY 30, STE 101
AMSTERDAM, NY 12010
Ph: (518) 843-6860
Fax: (518) 684-0156
WWW.EASTERNMED.COM

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CONSENT FOR TREATMENT & RELEASE OF INFORMATION

I consent to receiving treatment and/or a physical examination to be performed by the physician, nurse practitioner and/or professional staff at the Occupational Health Center. I permit the physician, nurse practitioner, and or staff of Eastern Med, LLC to treat me in ways they judge beneficial to me or have been requested by my employer or prospective employer. I understand that this care may include tests, physical examinations, immunizations and the drawing of my blood.

I further consent that the medical information and results of such test or treatment that is related to my job / job functions may be released to the guarantor (Example: The company authorizing and paying for the medical services or their agents).

PERMISSION TO CONTACT YOUR MEDICAL PROVIDER(S)
&
PRIVACY STATEMENT / HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

During the completion of your medical exam, significant findings may be identified which could have an impact on the performance of your work related duties. Further information from your medical provider(s) may be necessary to clear you for the employment or volunteer position you currently seek.

Please sign below if you agree to allow us to contact your medical provider(s) regarding significant medical findings, and / or additional information to clear you for your duties.

Furthermore, you also acknowledge that you have read and understand Eastern Med's HIPAA policy regarding the use of disclosure of protected health information, which is made in accordance with Federal Law (electronic version is available at www.easternmed.com/resources.php).

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

The patient is unable to give consent because: _____

Signature: _____ Date: _____

Relationship: _____

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Medical History

Name: _____ Sex: _____ Date of Birth: _____

Address: _____

Phone: _____

Have you ever had, or do you now have, any of the following? Check Yes or No, indicate age:

	Yes	No	Age
Surgery/Severe Injury			
Cancer/Tumor/Cyst			
Anemia/ Blood Disease			
Diabetes			
High Blood Pressure			
Thyroid Issues			
Skin Issues			
Ear/Nose/Throat Issues			
Eye Issues			
Lung Issues			
Heart Conditions			
Chicken Pox			
MMR			
Rheumatic/Scarlet Fever			
Phlebitis/ Blood Clot			

	Yes	No	Age
Abdominal/Ulcer Issues			
Kidney Disease/Stones			
Bladder/Prostate Issues			
Hernia (Rupture)			
Hemmorrhoids			
Varicose Veins			
Hand/Wrist/Arm Issues			
Foot/Ankle/Leg Issues			
Head/Neck/Spine Issues			
Back/Spine Pain			
Neurological Conditions			
Emotional Conditions			
Neuritis/Pinched Nerves			
Broken Bones			
Other			

If Yes, please explain: _____

_____

_____

_____

_____

Date of last tetanus shot: _____ Date of last Tuberculosis (TB) test: _____

Do you take mediciations? ____Yes ____No If Yes, please list them: _____

_____

_____

Are you allergic to any medications? ___Yes ___No If yes, to what? _____

Allergies other than medications: _____

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Do you currently smoke? ___Yes ___No If yes, # of cigarettes per day: ____ # of years: ____

If no, did you previously smoke? ___Yes ___ No If yes, # of cigarettes per day: ____ #of years: ____

Do you drink alcoholic beverages? ___Yes ___No If yes, how much? _____

Have you used illegal drugs in the past 2 years? ___Yes ___No

Do you now, or have you ever, belonged to a substance abuse support group? ___Yes ___No

Do you, or have you, lived next door to or very near an industrial plant? ___Yes ___No

Do you have a hobby or craft which you do at home? ___Yes ___No

Do you use pesticides around your home or garden? ___Yes ___ No

---

Occupational History

Company: _____

Job: _____

Please List most recent job first, and then work backwards in time:

Approximate Dates	Employer Name and Location	Known Health Hazard Exposure

1. Have you ever been rejected or uprated for insurance because of your health? ___Yes ___No
2. Have you been rejected from employment, or the Armed Forces, because of health? ___Yes ___No
3. Has your work ever been limited or restricted because of health? ___Yes ___No
4. Have you ever filed a Workers Compensation claim? ___Yes ___No
5. Have you ever received benefits from a Workers Compensation claim? ___Yes ___No
6. Have you lost more than five consecutive days from work, in the past three years, because of illness or injury? ___Yes ___No
7. Do you have a condition requiring a special work assignment or work aids? ___Yes ___No
8. Have you developed hearing problems from noise exposure? ___Yes ___No
9. Have you had problems due to work with vibrating tools? ___Yes ___No

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10. Have you had occupational radiation exposure? ___Yes ___No

11. Have you had problems because of exposure to solvents, fumes, chemicals, dust, or latex? ___Yes ___No

12. Have you had problems with any occupational materials irritating to you? ___Yes ___No

If Yes, please explain: _____

_____

_____

_____

_____

To the best of my knowledge, I certify that the above answers are true and complete.

Signature: _____ Date: _____

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Part 1

Asbestos Initial Medical Questionnaire

1. **Name:** _____ 2. **Present Occupation:** _____

3. **Clock Number:** _____ 4. **Plant:** _____

5. **Address:** _____ **City:** _____ **State:** _____ 6. **Zip Code:** _____

7. **Telephone Number:** _____ 8. **Interviewer:** _____

9. **Date:** _____ 10. **Date of Birth:** _____

11. **Place of Birth:** _____

12. Sex:
1. ☐ Male 2. ☐ Female

13. What is your marital status?
1. ☐ Single 2. ☐ Married 3. ☐ Widowed 4. ☐ Separated/ Divorced

14. Race
1. ☐ White 2. ☐ Black / African American 3. ☐ Asian 4. ☐ Hispanic / Latino
5. ☐ American Indian or Alaskan Native 6. ☐ Native Hawaiian or Pacific Islander

15. What is the highest grade completed in school? _____ (*For example, 12 years is completion of high school*)

Occupational History

16A. Have you ever worked full time (30 hours per week or more) for 6 months or more?
1. ☐ Yes 2. ☐ No

IF YES TO 16A:

B. Have you ever worked for a year or more in any dusty job?
1. ☐ Yes 2. ☐ No 3. ☐ Does Not Apply

Specify job/industry _____ Total Years Worked _____

Was dust exposure:
1. ☐ Mild 2. ☐ Moderate 3. ☐ Severe

C. Have you ever been exposed to gas or chemical fumes in your work?
1. ☐ Yes 2. ☐ No

Specify job/industry _____ Total Years Worked _____

Was exposure: 1. ☐ Mild 2. ☐ Moderate 3. ☐ Severe

D. What has been your usual occupation or job -- the one you have worked at the longest?

1. Job occupation _____

2. Number of years employed in this occupation _____

3. Position/job title _____

4. Business, field or industry _____
(Record on lines the years in which you have worked in any of these industries, e.g. 1960-1969)

Have you ever worked:

YES	NO			
☐	☐	E. In a mine?	_____	_____
☐	☐	F. In a quarry?	_____	_____
☐	☐	G. In a foundry?	_____	_____
☐	☐	H. In a pottery?	_____	_____
☐	☐	I. In a cotton, flax or hemp mill?	_____	_____
☐	☐	J. With asbestos?	_____	_____

17. Past Medical History

YES	NO	
☐	☐	A. Do you consider yourself to be in good health? If "NO" state reason _____
☐	☐	B. Have you any defect of vision? ..... If "YES" state nature of defect _____
☐	☐	C. Have you any hearing defect? ..... If "YES" state nature of defect _____
☐	☐	D. Are you suffering from or have you ever suffered from:

YES	NO	
☐	☐	a. Epilepsy (or fits, seizures, convulsions)?
☐	☐	b. Rheumatic fever?
☐	☐	c. Kidney disease?
☐	☐	d. Bladder disease?
☐	☐	e. Diabetes?
☐	☐	f. Jaundice?

18. Chest Colds and Chest Illnesses

18A. If you get a cold, does it "usually" go to your chest? ("Usually" means more than 1/2 the time)

1. ☐ Yes 2. ☐ No 3. ☐ Don't get colds

19A. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?

1. ☐ Yes 2. ☐ No

IF YES TO 19A:

B. Did you produce phlegm with any of these chest illnesses?

1. ☐ Yes 2. ☐ No 3. ☐ Does Not Apply

C. In the last 3 years, how many such illnesses with (increased) phlegm did you have which lasted a week or more?

Number of illnesses: _____ ☐ No such illnesses

20. Did you have any lung trouble before the age of 16?

1. ☐ Yes 2. ☐ No

21. Have you ever had any of the following?

1A. Attacks of bronchitis?

1. ☐ Yes 2. ☐ No

IF YES TO 1A:

B. Was it confirmed by a doctor?

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

C. At what age was your first attack?

Age in Years ___ ☐ Does Not Apply

2A. Pneumonia (include bronchopneumonia)?

1. ☐ Yes 2. ☐ No

IF YES TO 2A:

B. Was it confirmed by a doctor?

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

C. At what age did you first have it?

Age in Years ___ ☐ Does Not Apply

3A. Hay Fever?

1. ☐ Yes 2. ☐ No

IF YES TO 3A:

B. Was it confirmed by a doctor?

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

C. At what age did it start?

Age in Years ___ ☐ Does Not Apply

22A. Have you ever had chronic bronchitis?

1. ☐ Yes 2. ☐ No

IF YES TO 22A:

B. Do you still have it?

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

C. Was it confirmed by a doctor?

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

D. At what age did it start?

Age in Years ___ ☐ Does Not Apply

23A. Have you ever had emphysema?

1. ☐ Yes 2. ☐ No

IF YES TO 23A:

B. Do you still have it?

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

C. Was it confirmed by a doctor?

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

D. At what age did it start?

Age in Years ___ ☐ Does Not Apply

24A. Have you ever had asthma?

1. ☐ Yes 2. ☐ No

IF YES TO 24A:

B. Do you still have it?

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

C. Was it confirmed by a doctor?

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

D. At what age did it start?

Age in Years ___ ☐ Does Not Apply

E. If you no longer have it, at what age did it stop?

Age stopped: ____ ☐ Does not Apply

25. Have you ever had:

YES	NO	
☐	☐	A. Any other chest illness? If yes, please specify _____
☐	☐	B. Any chest operations? If yes, please specify _____

YES NO

☐ ☐ C. Any chest injuries?
If yes, please specify _____

☐ ☐ 26A. Has a doctor ever told you that you had heart trouble?

IF YES TO 26A:
B. Have you ever had treatment for heart trouble in the past 10 years?
1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

27A. Has a doctor told you that you had high blood pressure?
1. ☐ Yes 2. ☐ No

IF YES TO 27A:
B. Have you had any treatment for high blood pressure (hypertension) in the past 10 years?
1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

28. When did you last have your chest X-rayed? (Year) ___ ___ ___ ___

29. Where did you last have your chest X-rayed (if known)?
_____

What was the outcome? _____

Family History

30. Were either of your natural parents ever told by a doctor that they had a chronic lung condition such as:

	Father			Mother		
	Yes	No	Don't Know	Yes	No	Don't Know
A. Chronic Bronchitis?	☐	☐	☐	☐	☐	☐
B. Emphysema?	☐	☐	☐	☐	☐	☐
C. Asthma?	☐	☐	☐	☐	☐	☐
D. Lung cancer?	☐	☐	☐	☐	☐	☐
E. Other chest conditions?	☐	☐	☐	☐	☐	☐
F. Is parent currently alive?	☐	☐	☐	☐	☐	☐

G. Please Specify:

Father	Mother
___ Age if Living	___ Age if Living
___ Age at Death	___ Age at Death
___ Don't Know	___ Don't Know

H. Please specify cause of death

Father: _____ **Mother**: _____

Cough

YES NO

☐ ☐ 31A. Do you usually have a cough? (Count a cough with first smoke or on first going out of doors. Exclude clearing of throat.) **(If no, skip to question 31C.)**

☐ ☐ B. Do you usually cough as much as 4 to 6 times a day 4 or more days out of the week?

☐ ☐ C. Do you usually cough at all on getting up or first thing in the morning?

☐ ☐ D. Do you usually cough at all during the rest of the day or at night?

IF YES TO ANY OF ABOVE (31A, B, C, OR D,), ANSWER THE FOLLOWING. IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO NEXT PAGE

E. Do you usually cough like this on most days for 3 consecutive months or more during the year?

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

F. For how many years have you had the cough?

Number of Years ____ ☐ Does Not Apply

32A. Do you usually bring up phlegm from your chest? (Count phlegm with the first smoke or on first going out of doors. Exclude phlegm from the nose. Count swallowed phlegm.) **(If no, skip to 32C)**

1. ☐ Yes 2. ☐ No

B. Do you usually bring up phlegm like this as much as twice a day 4 or more days out of the week?

1. ☐ Yes 2. ☐ No

C. Do you usually bring up phlegm at all on getting up or first thing in the morning?

1. ☐ Yes 2. ☐ No

D. Do you usually bring up phlegm at all on during the rest of the day or at night?

1. ☐ Yes 2. ☐ No

IF YES TO ANY OF THE ABOVE (32A, B, C, OR D), ANSWER THE FOLLOWING:

IF NO TO ALL, CHECK "DOES NOT APPLY" AND SKIP TO 33A

E. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

F. For how many years have you had trouble with phlegm?

Number of Years ____ ☐ Does Not Apply

EPISODES OF COUGH AND PHLEGM

33A. Have you had periods or episodes of (increased*) cough and phlegm lasting for 3 weeks or more each year?
*(For persons who usually have cough and/or phlegm)

1. ☐ Yes 2. ☐ No

IF YES TO 33A

B. For how long have you had at least 1 such episode per year?

Number of Years ____ ☐ Does Not Apply

Wheezing

34A. Does your chest ever sound wheezy or whistling:

YES	NO	
☐	☐	1. When you have a cold?
☐	☐	2. Occasionally apart from colds?
☐	☐	3. Most days or nights?

B. For how many years has this been present?

Number of Years ____ ☐ Does Not Apply

35A. Have you ever had an attack of wheezing that has made you feel short of breath?

1. ☐ Yes 2. ☐ No

IF YES TO 35A

B. How old were you when you had your first such attack?

Age in Years ___ ☐ Does Not Apply

C. Have you had 2 or more such episodes?

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

D. Have you ever required medicine or treatment for the(se) attack(s)?

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

Breathlessness

36. If disabled from walking by any condition other than heart or lung disease, please describe and proceed to question 38A.

Nature of condition(s) _____

_____

37A. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

IF YES TO 37A

B. Do you have to walk slower than people of your age on the level because of breathlessness?

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

C. Do you ever have to stop for breath when walking at your own pace on the level?

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

D. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level?

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

E. Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs?

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

Tobacco Smoking

38A. Have you ever smoked cigarettes? (No means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime or less than 1 cigarette a day for 1 year.)

1. ☐ Yes 2. ☐ No

IF YES TO 38A

B. Do you now smoke cigarettes (as of one month ago)

1. ☐ Yes 2. ☐ No 3. ☐ Does not Apply

C. How old were you when you first started regular cigarette smoking?

Age in Years ___ ☐ Does Not Apply

D. If you have stopped smoking cigarettes completely, how old were you when you stopped?

1. Age stopped: ____ 2. ☐ Still smoking 3. ☐ Does Not Apply

E. How many cigarettes do you smoke per day now?

Cigarettes per day ____ ☐ Does Not Apply

F. On the average of the entire time you smoked, how many cigarettes did you smoke per day?

Cigarettes per day ____ ☐ Does Not Apply

G. Do or did you inhale the cigarette smoke?

1. ☐ Does not apply
2. ☐ Not at all
3. ☐ Slightly
4. ☐ Moderately
5. ☐ Deeply

39A. Have you ever smoked a pipe regularly? (Yes means more than 12 oz. of tobacco in a lifetime.)

1. ☐ Yes 2. ☐ No

IF YES TO 39A:

FOR PERSONS WHO HAVE EVER SMOKED A PIPE

B. 1. How old were you when you started to smoke a pipe regularly? Age: ___

2. If you have stopped smoking a pipe completely, how old were you when you stopped?

Age stopped: ____ ☐ Still smoking a pipe ☐ Does Not Apply

C. On the average over the entire time you smoked a pipe, how much pipe tobacco did you smoke per week?

___ oz. per week (a standard pouch of tobacco contains 1 1/2 oz.)

☐ Does Not Apply

D. How much pipe tobacco are you smoking now?

oz. per week ___ ☐ Not currently smoking a pipe

E. Do you or did you inhale the pipe smoke?

1. ☐ Never smoked
2. ☐ Not at all
3. ☐ Slightly
4. ☐ Moderately
5. ☐ Deeply

40A. Have you ever smoked cigars regularly? (Yes means more than 1 cigar a week for a year)

1. ☐ Yes 2. ☐ No

IF YES TO 40A

FOR PERSONS WHO HAVE EVER SMOKED A CIGARS

B. 1. How old were you when you started smoking cigars regularly? Age ___

2. If you have stopped smoking cigars completely, how old were you when you stopped.

1. Age stopped: ____ 2. ☐ Still smoking 3. ☐ Does Not Apply

C. On the average over the entire time you smoked cigars, how many cigars did you smoke per week?

Cigars per week ____

☐ Does Not Apply

D. How many cigars are you smoking per week now?

Cigars per week ___

☐ Check if not smoking cigars currently

E. Do or did you inhale the cigar smoke?

1. ☐ Never smoked
2. ☐ Not at all
3. ☐ Slightly
4. ☐ Moderately
5. ☐ Deeply

Signature: _____ **Date:** _____

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Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee:

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section

1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:_____

2. Your name:_____

3. Your age (to nearest year):_____

4. Sex (circle one): Male/Female

5. Your height: _____ ft. _____ in.

6. Your weight: _____ lbs.

7. Your job title:_____

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____

9. The best time to phone you at this number: _____

*For all **Yes** or **No** questions please **circle** the best answer that pertains to you*

Yes / No 10. Has your employer told you how to contact the health care professional who will review this questionnaire

11. Check the type of respirator you will use (you can check more than one category):
a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
b. _____ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, SCBA).

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Yes / No 12. Have you worn a respirator

If "yes," what type(s):_____
_____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

Yes / No **1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month**

2. Have you *ever had* any of the following conditions?

Yes / No 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

3. Have you *ever had* any of the following pulmonary or lung problems?

Yes / No 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 j. Broken ribs

Yes / No k. Any chest injuries or surgeries

Yes / No l. Any other lung problem that you've been told about

4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?

Yes / No 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

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

Yes / No a. Heart attack

Yes / No 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

6. Have you *ever had* any of the following cardiovascular or heart symptoms?

Yes / No 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 d. Any other symptoms that you think may be related to heart or circulation problems

7. Do you *currently* take medication for any of the following problems?

Yes / No a. Breathing or lung problems

Yes / No b. Heart trouble

Yes / No c. Blood pressure

Yes / No d. Seizures

8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator go to question 9:)

Yes / No 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 9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire

Questions 10 to 15 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.

Yes / No 10. Have you *ever lost* vision in either eye (temporarily or permanently)

11. Do you *currently* have any of the following vision problems?

Yes / No 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 12. Have you *ever had* an injury to your ears, including a broken ear drum

13. Do you *currently* have any of the following hearing problems?

Yes / No a. Difficulty hearing

Yes / No b. Wear a hearing aid

Yes / No c. Any other hearing or ear problem

Yes / No 14. Have you *ever had* a back injury

15. Do you *currently* have any of the following musculoskeletal problems?

Yes / No 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 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

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

Yes / No 1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen

Yes / No If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions

Yes / No 2. 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

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

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

Yes / No 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 h. Tin

Yes / No i. Dusty environments

Yes / No j. Any other hazardous exposures

If "yes," describe these exposures:_____
_____
_____

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

5. List your previous occupations: _____
_____

6. List your current and previous hobbies: _____
_____

Yes / No **7. Have you been in the military services?**

Yes / No If "yes," were you exposed to biological or chemical agents (either in training or combat)

Yes / No **8. Have you ever worked on a HAZMAT team?**

Yes / No **9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)**

If "yes," name the medications if you know them:_____

10. Will you be using any of the following items with your respirator(s)?

Yes / No a. HEPA Filters

Yes / No b. Canisters (for example, gas masks)

Yes / No c. Cartridges

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?

Yes / No a. Escape only (no rescue)

Yes / No b. Emergency rescue only

Yes / No c. Less than 5 hours *per week*

Yes / No d. Less than 2 hours *per day*

Yes / No e. 2 to 4 hours per day

Yes / No f. Over 4 hours per day

12. During the period you are using the respirator(s), is your work effort:

Yes / No a. *Light* (less than 200 kcal per hour)

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of a light work effort are *sitting* while writing, typing, drafting, or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines.

Yes / No b. *Moderate* (200 to 350 kcal per hour)

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Yes / No Examples of moderate work effort are *sitting* while nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; *walking* on a level surface about 2 mph or down a 5-degree grade about 3 mph; or *pushing* a wheelbarrow with a heavy load (about 100 lbs.) on a level surface. c. *Heavy* (above 350 kcal per hour)

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of heavy work are *lifting* a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; *shoveling; standing* while bricklaying or chipping castings; *walking* up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

Yes / No 13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator

If "yes," describe this protective clothing and/or equipment:_____

Yes / No 14. Will you be working under hot conditions (temperature exceeding 77 deg. F)

Yes / No 15. Will you be working under humid conditions

16. Describe the work you'll be doing while you're using your respirator(s):

_____
_____

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

_____
_____

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
Name of the second toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
Name of the third toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
The name of any other toxic substances that you'll be exposed to while using your respirator:

_____
_____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, and security):

_____

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998; 76 FR 33607, June 8, 2011; 77 FR 46949, Aug. 7, 2012]

SURGICAL HISTORY

Surgical Procedure	Date
Surgical Procedure	Date
Surgical Procedure	Date
Surgical Procedure	Date

MEDICATION LIST

Please list any medications that you are currently taking:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

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5010 STATE HWY 30, STE 101
AMSTERDAM, NY 12010
PH: (518) 843-6860
FAX: (518) 684-0156
WWW.EASTERNMED.COM

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Respirator Fit Test Fact Sheet

Respirators are an effective method of protection against hazardous materials when properly selected and worn. When you wear a respirator you should follow these guidelines.

1. Read and heed all instructions provided by the manufacturer on use, maintenance, cleaning and care, as well as any warnings regarding the respirators limitations.
2. A label or statement of certification should appear on the respirator or respirator packaging to tell you what the respirator is designed for and how much it will protect you.
3. Do not wear your respirator into an atmosphere containing contaminants for which your respirator is not designed to protect. (For example, a respirator designed to filter dust particles will not protect you against gases).
4. Every time you wear a respirator, make sure it gives you a good seal by checking the fit to your face before each use.
5. Inspect the respirator for any defects making sure it is clean and check all seals of the respirator.
6. Facial hair that comes between the sealing surfaces of the face piece and the face or that which interferes with value function shall prohibit the use of the respirator. All facial hair must be removed with the exception of a mustache.
7. Report any change that could affect respirator fit to your employer such as facial scarring, dental changes, cosmetic surgery, or a change in weight of plus or minus 10 LBS.
8. Your fit test is specific to the mask type and manufacturer you are being fit for. If the type or manufacturer of your mask changes, you will need to be refit.
9. Please revert to OSHA RESPIRATOR STANDARD 1910.134 for further information on the standard. Check with your safety officer for assistance with regulations.
10. Never use alcohol to clean respirator mask. Do not use any cleaner with fragrance. Use a specialized cleaner or plain soap and water.
11. Always allow mask to air dry in a well ventilated area following each cleaning.
12. Change cartridges as often as needed. If the respirator is used for paint, change the pad frequently if not better, change the cartridge. If used for block work, change cartridges frequently (Daily if needed, minimum of weekly).
13. Your fit test is good for a period of one year.
14. Your respirator is provided for your safety. Be sure you understand how, why, and when to use it.

Fact sheet reviewed by: _____ Date: _____

Employee Signature: _____ Date: _____

EASTERN MED
5010 STATE HWY 30, STE 101
AMSTERDAM NY, 12010
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FAX: (518) 684-0156
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Respiratory Fit Testing Record

Name: _____ **Date:** _____

Company Name: _____ **Job Title:** _____

FIT TEST

Irritant Used: Bitrex / Saccharin

Method used: Qualitative / Quantitative

Results: Passed Failed **If failed,** please enter comment: _____

Overall Fit Factor (Quantitative only): _____

RESPIRATORY ISSUANCE AND TRAINING

Respirator Style: _____ **NIOSH #:**_____

Model #:_____ **Size:** SMALL MEDIUM LARGE

INSTRUCTIONS FOR USE

- Employee has been informed of the OSHA Respirator Standard
- Employee verbalizes understanding of the conditions for use of the respirator
- Employee is able to don the respirator independently
- Employee is able to perform positive/negative pressure check with respirator on
- Employee understands process for inspecting , cleaning, disinfecting, maintaining and storing or the respirator with each use,
- Employee understands the limits of a respirator and conditions, which will require new fit testing.

Fit Tester Signature: _____ Date: _____

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5010 STATE HWY 30, STE 101
AMSTERDAM, NY 12010
PH: (518) 843-6860
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RESPIRATOR CLEARANCE- EXAMINER'S WRITTEN OPINION

Employee Name: _____ Date _____

Job title: _____ Employer: _____

Based on review of the OSHA Respirator Health Questionnaire (CFR 1910.134), Interview, physical examination or further evaluation as appropriate, this individual is:

- *Medically approved for* all respirators with the exception of SCBA and subject to fit test.
- *Medically not approved* to wear any type of respirator.

BASED ON INTERVIEW, PHYSICAL EXAMINATION AND FURTHER EVALUATION AS APPROPRIATE, THIS INDIVIDUAL IS;

- Medically approved for all respirators including SCBA and subject to fit testing: _____
- Medically approved for only the following types subject to satisfactory fit testing: _____
- Dusk Mask
- Negative Pressure
- Powered air purifying respirator
- Supplied Air
- Self-contained breathing apparatus (SCBA)
- Employee may decline respirator required assignments for temporary health related difficulties
- Respirator assignment must not be for IDHL (Immediate Danger to Life and Health) environments
- Employee should not be expected to perform rescue duty or serve as a member of a rescue team
- Requires further medical information /evaluation prior to qualifying for respirator use.
- Other recommendations and suggested accommodations

Recommended time period for next exam: 1 YEAR

Notes (optional):

_____

_____

_____

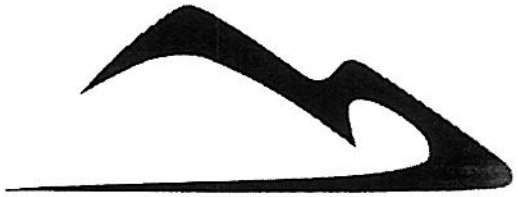
_____

The employee has been notified of the results of this evaluation, and has been provided a copy of this written recommendation.

_____

Medical Examiner's Signature

EASTERN MED, LLC
5010 STATE HWY 30, STE 101
AMSTERDAM, NY 12010
PH: (518) 843-6860
FAX: (518) 843-0156
WWW.EASTERNMED.COM



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NAME: _____ **DATE OF EXAM**_____

MEDICAL RECOMMENDATIONS:

- ○ Able to perform this job without accommodations:
- ○ Drug Screen
  - ○ Negative
  - ○ Pending Drug Screen Results
  - ○ Positive for _____

- ○ Limited due to physical and health status as follows:
  - ○ Ground level work only
  - ○ No hazardous machinery
  - ○ No driving motor vehicles
  - ○ Avoid skin irritants
  - ○ No heavy lifting over 45 lbs
  - ○ Moderate lifting 15-45 lbs
  - ○ Avoid lung irritants
  - ○ Other_____
- ○ Acknowledgement of physical defect required: defect is_____

- ○ Employable for specific job: no transfer to another job or area without medical approval.
- ○ Employable after corrected medical condition.
- ○ Employable with reasonable accommodation.

- ○ Not recommended for employment due to medical condition.

Comments:_____

_____ Date: _____

Signature of Medical Provider

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JOB: _____

EMPLOYER: _____

PHYSICAL EXAMINATION:

NAME: _____ DATE: _____

DATE OF BIRTH: _____

VITAL SIGNS: HGT: _____ WT: _____ B/P: _____ PULSE _____

URINALYSIS: PROTEIN: _____ GLUCOSE: _____

	WITHOUT GLASSES			WITH GLASSES/CONTACTS		
VISION	BOTH: 20/_____	RIGHT 20/_____	LEFT: 20/_____	BOTH: 20/_____	RIGHT: 20/ _____	LEFT: 20/_____

COLOR BLIND (ISHIHARA): PLATE 1 2 3 4 5 6 7 8 9 10 11

NORMAL _____

ABNORMAL _____

HEARING	500 Hz	1000 Hz	2000Hz	4000Hz
RIGHT:	20 25 40	20 25 40	20 25 40	20 25 40
LEFT:	20 25 40	20 25 40	20 25 40	20 25 40

WHISPER TEST: AD _____ AS _____

SIGNATURE: _____

General Appearance:	Normal	Mental Status:	Normal
Skin:	Normal	Abd:	Normal:
HEENT:	Normal	Ing/Hernia:	Normal
Neck:	Normal	Exts:	Normal
Thorax:	Normal	Neuro:	Normal
Heart:	Normal	Reflexes:	Normal

COMMENTS/ SUMMARY:

Signature of Medical Provider: _____

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