



Office of Health Services

UNITED STATES MERCHANT MARINE ACADEMY

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Respiratory Protection Medical Questionnaire Form

The purpose of this required Pulmonary Function screening is to establish an initial baseline screen and medically clear each Midshipman for sea duty training with respirators. Please complete this three-page document in its entirety without making any modifications to the questions.

Date: _____

Last Name: _____ First Name: _____

Last 4 Digits of Social Security Number: _____ Date of Birth: _____ Age: _____

Gender: Male: ___ Female: ___ Height: _____ ft. _____ in. Weight: _____ lbs.

Ethnicity: White ___ Asian ___ Black ___ Hispanic ___ Native American ___ Other: _____

Have you worn a respirator before? Yes ___ No ___

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

If applicable, describe the work you will be doing while wearing a respirator: As part of my training on how to fight fires onboard ship I will have to wear a respirator

If you know them, describe the possible chemicals, gases, dusts, or toxic substances you might be exposed to while wearing a respirator: As part of Sea Year deployment requirements, I may be exposed to benzene/petroleum products/grain dust/other particulates

Do you currently smoke tobacco or have you smoked tobacco in the last month? Yes ___ No ___

List any medications you currently take: Name, dose, date prescribed.

Have you <u>ever</u> had any of the following?		
Mark "yes" or "no" (ANSWER ALL)	Y	N
Emphysema		
Pneumonia		
Tuberculosis		
Silicosis		
Pneumothorax (collapsed lung)		
Lung cancer		
Broken ribs		
Any chest injuries or surgeries		
Any other lung problems that you've been told about		
Heart attack		
Stroke		
Angina		
Heart failure		
Swelling in 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		
Seizures (fits)		
Diabetes (sugar disease)		
Allergic reactions that interfere with your breathing		
Claustrophobia (fear of closed-in places)		
Trouble smelling odors		
Asbestosis		
Asthma		
Chronic bronchitis		
Have you <u>ever</u> had any of the following cardio-vascular or heart symptoms?		
Mark "yes" or "no" (ANSWER ALL)	Y	N
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 symptoms that you think may be related to heart or circulation problems (specify):		

Do you <u>currently</u> have the following?		
Mark "yes" or "no" (ANSWER ALL)	Y	N
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 (specify):		
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 job		
Coughing that produces phlegm		
Coughing that wakes you early in the morning		

Do you <u>currently</u> take medication for any of the following problems?		
Mark "yes" or "no" (ANSWER ALL)	Y	N
Breathing or lung problems		
Heart trouble		
Blood pressure problems		

**Additional questions required for respirator use that requires
Full-Face piece or Self-Contained Breathing Apparatus (SCBA)**

Have you <u>ever</u> had any of the following?		
Mark "yes" or "no" (ANSWER ALL)	Y	N
Loss of vision in either eye (temporarily or permanently)		
Back injury		
Injury to your ears, including broken ear drum		

Do you <u>currently</u> have the following?		
Mark "yes" or "no" (ANSWER ALL)	Y	N
Wear contact lenses		
Wear glasses		
Color blind		
Any other eye or vision problem (specify):		
Difficulty hearing		
Wear a hearing aid		
Any other hearing or ear problems (specify):		
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 and 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 lbs.		
Any other muscular or skeletal problem that interferes with using a respirator (specify):		

Signature of Plebe Candidate _____ Date _____

Signature of Parent/Legal Guardian for Minors _____ Date _____

Print Name _____

Print Name _____ Relationship to Plebe Candidate _____