Office of Health Services

UNITED STATES MERCHANT MARINE ACADEMY
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2017 - 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.

_____

_____

_____

Last name, First name _____

Have you ever had any of the following? Circle "yes" or "no" (ANSWER ALL)			Do you currently have the Following? Circle "yes or "no" (ANSWER ALL)		
Emphysema	Y	N	Coughing that occurs mostly when you are lying down	Y	N
Pneumonia	Y	N	Coughing up blood in the last month	Y	N
Tuberculosis	Y	N	Wheezing	Y	N
Silicosis	Y	N	Wheezing that interferes with your job	Y	N
Pneumothorax (collapsed lung)	Y	N	Chest pain when you breathe deeply	Y	N
Lung cancer	Y	N	Any other symptoms that you think may be related to lung problems	Y	N
Broken ribs	Y	N	Do you currently take medication for any of the following problems?	Y	N
Any chest injuries or surgeries	Y	N	Breathing or lung problems	Y	N
Any other lung problems that you've been told about	Y	N	Heart trouble	Y	N
Heart attack	Y	N	Blood pressure problems	Y	N
Stroke	Y	N			
Angina	Y	N			
Heart failure	Y	N	If you've used a respirator, have you ever had any of the following problems? (ANSWER ALL)		
Swelling in your legs or feet (not caused by walking)	Y	N	Eye irritation	Y	N
Heart arrhythmia (heart beating irregularly)	Y	N	Skin allergies or rashes	Y	N
High blood pressure	Y	N	Anxiety	Y	N
Any other heart problem that you've been told about	Y	N	General weakness or fatigue	Y	N
Have you ever had any of the following cardiovascular or heart symptoms?	Y	N	Any other problem that interferes with your use of a respirator	Y	N
Frequent pain or tightness in your chest	Y	N			
Pain or tightness in you chest during physical activity	Y	N			
Pain or tightness in your chest that interferes with your job	Y	N			
In the past two years, have you noticed your heart skipping or missing a beat	Y	N	Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	Y	N
Heartburn or indigestion that is not related to eating	Y	N			
Any other symptoms that you think may be related to heart or circulation problems	Y	N			
Seizures (fits)	Y	N	Shortness of breath	Y	N
Diabetes (sugar disease)	Y	N	Shortness of breath when walking fast on level ground or walking up a slight hill or incline	Y	N
Allergic reactions that interfere with you breathing	Y	N	Shortness of breath when walking with other people at an ordinary pace on level ground	Y	N
Claustrophobia (fear of closed-in places)	Y	N	Have to stop for breath when walking at your own pace on level ground	Y	N
Trouble smelling odors	Y	N	Shortness of breath when washing or dressing yourself	Y	N
Asbestosis	Y	N	Shortness of breath that interferes with job	Y	N
Asthma	Y	N	Coughing that produces phlegm	Y	N
Chronic bronchitis	Y	N	Coughing that wakes you early in the morning	Y	N

Last name, First name _____

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

Have you ever lost vision in either eye (temporary or permanently)	Y	N	Have you ever had a back injury	Y	N
Do you currently have any of the following vision problems?	Y	N	Do you currently have any of the following musculoskeletal problems? (ANSWER ALL)		
Wear contact lenses	Y	N	Weakness in any of you arms, hands, legs, or feet	Y	N
Wear glasses	Y	N	Back pain	Y	N
Color blind	Y	N	Difficulty fully moving you arms and legs	Y	N
Any other eye or vision problem	Y	N	Pain or stiffness when you lean forward or backward at the waist	Y	N
Have you ever had an injury to your ears, including a broken ear drum	Y	N	Difficulty fully moving your head up and down	Y	N
Do you currently have any of the following hearing problems? (ANSWER ALL)			Difficulty fully moving your head side to side	Y	N
Difficulty hearing	Y	N	Difficulty bending at your knees	Y	N
Wear a hearing aid	Y	N	Difficulty squatting to the ground	Y	N
Any other hearing or ear problems	Y	N	Climbing A flight of stairs or a ladder carrying more than 25 lbs.	Y	N
			Any other muscle or skeletal problem that interferes with using a respirator	Y	N

Signature of Plebe Candidate Date

Signature of Parent/Legal Guardian for Minors Date

Print Name

Print Name Relationship to Plebe Candidate