FIRE TECHNOLOGY — MORENO VALLEY COLLEGE

ALL QUESTIONS MUST BE ANSWERED COMPLETELY WITH A YES, NO, NONE OR NOT APPLICABLE. FOR HEALTHCARE PROVIDER REVIEW ONLY. DO NOT SUBMIT QUESTIONNAIRE WITH APPLICATION. ONLY PHYSICAL RESULTS (LAST) PAGE.

Date: _____ Last 4 SSN: _____

Last Name: _____ First Name: _____ MI: _____ Suffix: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone No: _____ Alternate Phone No: _____ Date of Birth: _____ Age: _____

To the Applicant: Can you read (check one): Yes ☐ No ☐

The medical questionnaire was developed by Cal/OSHA as part of the comprehensive medical evaluation process to determine fitness to use respiratory protection equipment. ***For your protection and privacy, it is important that this confidential medical questionnaire not be shared with those not involved in the medical review process.***

Part A - Section 1**. The following information must be provided by every applicant required to use any type of respirator (please print).**

1. Sex (check one): ☐ Male ☐ Female
2. Your height _____ Ft. _____ In.
3. Your weight: _____ Lbs
4. Your job title: _____
5. Phone number where you can be reached between the hours of 7:00 am and 4:30 pm by the health care professional who reviews this questionnaire (include Area code) _____
6. The best time during the hours of 7:00 am and 4:30pm to phone you at this number _____
7. Check the type of respirator you will use (Check all):
   a. ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
   b. ☐ Half- or full-facepiece type.
   c. ☐ Powered-air purifying, supplied-air.
   d. ☐ Self-contained breathing apparatus.
8. Have you worn a respirator? Yes ☐ No ☐
   If yes," what type(s):
   a. ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
   b. ☐ Half- or full-facepiece type.
   c. ☐ Powered-air purifying, supplied-air.
   d. ☐ Self-contained breathing apparatus.

Section 2. (Please check applicable "YES" or "NO" box.)

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes ☐ No ☐
2. Have you ever had any of the following conditions?
   a. Seizures (fits). 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 ☐
3. 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 ☐
   j. Broken ribs. Yes ☐ No ☐
   k. Any chest injuries or chest surgeries. Yes ☐ No ☐
   l. Any other lung problem that you have been told about. Yes ☐ No ☐

4. 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.	Need to stop for a 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 awakes 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 ☐

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

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.	Yes ☐	No ☐

6. 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 ☐

7. 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 (fits).	Yes ☐	No ☐

8. Have you taken any prescription or over the counter medications in the last 12 months? If yes, list prescription/medication name and dosage — Yes ☐ No ☐

9. If you have used a respirator, have you ever had any of the following problems? Check all that apply. — 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 ☐

10. Would you like to talk to the health care professional about your answers to this questionnaire? — Yes ☐ No ☐

11. Have you ever lost vision in either eye (temporarily or permanently)? — Yes ☐ No ☐

12. 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 ☐

13. Have you ever had an injury to your ears, including a broken eardrum? — Yes ☐ No ☐

14. 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 ☐

15. Have you ever had a back injury? Yes ☐ No ☐

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

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.	Yes ☐	No ☐

17. Have you had any surgical operations? If yes, list the type of surgery and when it was performed. Yes ☐ No ☐

Type of surgery _____ Date of surgery _____

18. Have you ever suffered from a heat-related illness? If yes, please describe: Yes ☐ No ☐

19. Are you currently under a doctor's care? Yes ☐ No ☐

20. Have you had any motor vehicle accidents with injuries? If yes, please describe. Yes ☐ No ☐

Part B

1. List medications you use on a regular basis while wearing protective equipment (include over-the-counter medications):

_____

_____

2. Have you ever had or been advised to have an exercise treadmill test? Yes ☐ No ☐

If **yes**, when was the last treadmill done? _____

Were you advised to restrict your activities based on the results? Yes ☐ No ☐

3. List **previous** occupations or activities which you believe may have exposed you to airborne toxic substances (include items such as pertinent military service, pesticide application, mining activities, rock drilling, asbestos abatement, lead abatement, etc.):

Previous Occupation/Activities Exposure

_____

4. List any **present** occupations or activities that you feel may expose you to airborne toxic substances (mining, smelting metals, welding, etc.):

Present Occupation/Activities Exposure

_____

_____

5. Are you on a HAZMAT Team? Yes ☐ No ☐

5a. When was your last medical clearance examination for HAZMAT work?

Date: _____

Final Question

Is there anything about your work or medical history that should be considered in determining your ability to perform your work activities while wearing protective equipment including any condition(s) not specifically referred to in the preceding questions? If yes, please advise: Yes ☐ No ☐

_____

_____

CERTIFICATION: I certify that I have provided true and complete information concerning my health.

_____ _____

APPLICANT SIGNATURE DATE

FIRE TECHNOLOGY MORENO VALLEY COLLEGE

OSHA Respiratory Medical Recommendation and Physical Results. Sign Both Areas for RPP and Physical Clearance.

Applicant Name (Last) (First) (Middle)		Provider Name
Applicant Address		Provider Address
Position Title Cadet Firefighter	Applicant's Current Occupation	Contact Name and Number

BELOW IS COMPLETED BY HEALTHCARE PROVIDER AFTER REVIEW OF RPP QUESTIONNAIRE AND PHYSICAL IS COMPLETED

HEALTHCARE PROVIDER ADMINISTRATIVE USE ONLY

RPP Questionnaire Results:

☐ **Cleared to be Fit Tested by Fire Academy Based on RPP Questionnaire:**

☐ **Referred to Physician for Further Evaluation:**

Provider Signature:	**Date:**

HEALTHCARE PROVIDER ADMINISTRATIVE USE ONLY

Physical Exam Results:

☐ **Full Clearance for Academy Activity:**

☐ **Referred to Physician for Further Evaluation:**

Provider Signature:	**Date:**