MEDCARE OCCUPATIONAL HEALTH
31047 State Highway 100 · Los Fresnos, TX 78566
+1 956-233-2103 · medcareocc@gmail.com

Employee Pre-Visit Packet

PKT-08

Complete these pages at home and bring them to your appointment. Print single-sided if you can.

YOUR DETAILS

Write your name and date of birth at the top of every form. Print clearly.

EMPLOYEE NAME

EMPLOYER / COMPANY

BRING THESE TO YOUR APPOINTMENT

- Government-issued photo ID, and your CDL if you have one
- A written list of your medications, with doses
- Glasses, contact lenses, or hearing aids if you use them
- Letters or forms from your doctors for any ongoing condition
- These completed pages — all of them, including blanks

FORMS IN THIS PACKET

FORM	TITLE	PAGES
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BEFORE YOU START

- Fill this out before you arrive. It saves you time in the waiting room and keeps the line moving.
- Answer every question honestly. Leaving something out can affect the accuracy of your clearance.
- Do not email these pages back to us. Bring them with you — they contain your medical information.
- Some sections may not apply to your job. Your employer or the clinic will tell you which to skip.
- If you need help, or want the forms in Spanish, call the clinic at 956-233-2103.

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PATIENT ID / RECORD # _____

Patient Registration & Consent for Evaluation

FORM MC-100

PATIENT INFORMATION

PATIENT NAME	DRIVER LICENSE #
DATE OF BIRTH	GENDER ☐ Male ☐ Female
HOME ADDRESS	CITY, STATE, ZIP
PHONE #	EMAIL
EMERGENCY PHONE #	BARCODE / CHAIN OF CUSTODY #

REASON FOR VISIT

SERVICES REQUESTED

☐ Urine Drug Test **(UDT)**	☐ Pre-Employment Physical Examination **(PEP)**
☐ Hair Follicle Drug Test **(HFDT)**	☐ DOT Physical Examination **(DOT PE)**
☐ Oral Fluid Drug Test **(OFDT)**	☐ Non-DOT Physical Examination **(NDP)**
☐ Breath Alcohol Test **(BAT)**	☐ HAZWOPER Medical Examination **(HME)**
☐ Random Drug Test **(RDT)**	☐ Firefighter Medical Examination **(FME)**
☐ Blood Collection **(BC)**	☐ Return to Work Evaluation **(RTW)**
☐ Medical Weight Management **(MWM)**	☐ Audiogram / Hearing Test **(AUD)**
	☐ Respirator Fit Test **(RFT)**

CONSENT FOR EVALUATION AND TREATMENT

I hereby consent to receive medical evaluation, treatment, and related occupational health services as deemed necessary by the licensed healthcare provider at MedCare Occupational Health PLLC. I understand that these services are provided for employment and occupational purposes, and that relevant results may be shared with my employer or their designated representative as permitted by law. I acknowledge that care provided by MedCare Occupational Health PLLC does not replace the medical care of my personal physician.

PATIENT SIGNATURE _____ DATE _____

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PATIENT ID / RECORD # _____

Consent / Authorization for Disclosure of PHI

FORM MC-101

PURSUANT TO 45 CFR 164.508

PATIENT IDENTIFICATION

FIRST NAME | LAST NAME | SSN / EMPLOYEE ID

DATE OF BIRTH | AGE | SEX ☐ Male ☐ Female | TODAY'S DATE

ADDRESS | CITY | STATE | ZIP

CELL / HOME PHONE | WORK PHONE | EMAIL

AUTHORIZATION

I HEREBY AUTHORIZE (CLINIC NAME)

CLINIC ADDRESS

to disclose medical information and/or protected health information (PHI) of the patient listed above to:

MedCare Occupational Health PLLC
31047 State Highway 100, Los Fresnos, TX 78566 · Phone +1 956-233-2103 · medcareocc@gmail.com

PURPOSE Evaluation requested by employer or prospective employer.

TREATMENT DATE(S) FROM | THROUGH

THIS AUTHORIZATION EXPIRES UPON THE FOLLOWING DATE OR EVENT

ACKNOWLEDGEMENTS

- If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Custodian of Records of the above facility. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.
- Fees/charges will comply with all laws and regulations applicable to release of information.
- I understand authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
- I specifically authorize written, oral and telefax communications with MedCare Occupational Health.
- I understand and agree that the results will be disclosed to my Company's representative and/or Medical Review Officer and hereby release MedCare Occupational Health, any employees and/or agents thereof from any and all claims or causes of actions resulting from the disclosure of these results. Additionally, in accordance with Federal Regulations, the Medical Review Officer is authorized to verify medical information supplied by me under the Department of Health and Human Services Mandatory Guidelines for Federal Workplace Drug Testing Programs (this information may include medical records from a hospital, my personal physician, dentist, or pharmacy records).

_____ INITIAL I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results and/or AIDS information.

I have read the above and authorize the disclosure of the protected health information as stated.

SIGNATURE _____ DATE _____

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PATIENT ID / RECORD # _____

Medical History Questionnaire

FORM MC-102

FIRST NAME | LAST NAME | SSN / EMPLOYEE ID

DATE OF BIRTH | AGE | SEX ☐ Male ☐ Female | TODAY'S DATE

PRESENT OCCUPATION | COMPANY

MEDICAL HISTORY

Mark every line. If you answer YES to any item, explain it in the space below.

CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N
Asthma / wheezing	☐	☐	Heart trouble	☐	☐	Neck pain	☐	☐
Pneumonia	☐	☐	Palpitation / pounding heart	☐	☐	Back pain / injury	☐	☐
Tuberculosis / lung disease	☐	☐	Pain / pressure in chest	☐	☐	Fractured / broken bones	☐	☐
Frequent bronchitis	☐	☐	High blood pressure	☐	☐	Swollen / stiff / painful joints	☐	☐
Shortness of breath	☐	☐	Diabetes	☐	☐	Amputations	☐	☐
Chronic cough	☐	☐	Stroke	☐	☐	Deformities of legs, feet, arms, hands, back or joints	☐	☐
Coughing up blood	☐	☐	Rheumatic fever	☐	☐	Loss of appetite	☐	☐
Sleep apnea / loud snoring	☐	☐	Bleeding disorder or issue	☐	☐	Unexplained weight change	☐	☐
Glasses / contacts	☐	☐	Inflammation of veins / clots	☐	☐	Tumors / abnormal growths	☐	☐
Glaucoma	☐	☐	Enlarged / varicose veins	☐	☐	Thyroid problems	☐	☐
Eye injury / operation / defects	☐	☐	Nausea / vomiting (frequent)	☐	☐	Hernia	☐	☐
Loss of hearing / ringing in ears	☐	☐	Vomiting up blood	☐	☐	Hemorrhoids	☐	☐
Headaches (frequent / severe)	☐	☐	Ulcer(s)	☐	☐	Venereal disease(s)	☐	☐
Head injury	☐	☐	Diarrhea (frequent / severe)	☐	☐	Allergies (drug, hay fever, food)	☐	☐
Blackouts / dizziness / fainting	☐	☐	Constipation (frequent / severe)	☐	☐	Currently taking medications	☐	☐
Epilepsy / seizures	☐	☐	Blood in bowel movement	☐	☐	Previous surgery(s)	☐	☐
Nervous disorders	☐	☐	Gallbladder trouble	☐	☐	Other illness or injury	☐	☐
Fear of heights	☐	☐	Kidney / bladder problems	☐	☐	Other: _____	☐	☐
Claustrophobia	☐	☐	Liver disease	☐	☐	Other: _____	☐	☐
Skin conditions	☐	☐	Cancer	☐	☐			

EXPLANATION OF ALL "YES" ANSWERS

_____

_____

LIFESTYLE & WORK HISTORY

	Y	N	IF YES
Current or former smoker	☐	☐	*Packs a day?* _____ *For how many years?* _____ *If former, how long ago did you quit?* _____
Do you drink alcoholic beverages?	☐	☐	*Drinks per week?* _____ *What type(s)?* _____
Have you ever had a drug or alcohol problem?	☐	☐	*Please explain:* _____

	Y	N	IF YES
Have you **ever** been injured at work?	☐	☐	*Please explain:* _____ *Company name & address:* _____
Have you **ever** received worker's comp benefits?	☐	☐	*Please list:* _____
Have you **ever** been placed on light duty from an injury?	☐	☐	*Please explain:* _____
Has any injury or illness left you with a physical limitation?	☐	☐	*Please explain:* _____

I understand that failure to answer truthfully may result in the denial of compensation benefits, including medical treatment and expenses. I hereby certify that the information provided above and the information which I will provide to the medical provider in connection with this examination is true and correct to the best of my knowledge. I understand that any omission of fact or false statement is sufficient grounds for denial of employment or, if employed, termination of my employment.

EMPLOYEE SIGNATURE _____

DATE _____

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PATIENT ID / RECORD # _____

Orthopedic History Questionnaire

FORM MC-103

FIRST NAME | LAST NAME | SSN / EMPLOYEE ID

DATE OF BIRTH | AGE | SEX ☐ Male ☐ Female | TODAY'S DATE

PRESENT OCCUPATION | COMPANY

MUSCULOSKELETAL HISTORY

Have you ever had pain in, or injured, any of the following?

BODY AREA	INJURED?	WHERE DID IT HAPPEN?	DATES, TREATMENT GIVEN, HOW LONG IT PERSISTED
Neck	☐ YES ☐ NO	☐ Home ☐ Work	
Shoulder	☐ YES ☐ NO	☐ Home ☐ Work	
Back	☐ YES ☐ NO	☐ Home ☐ Work	
Hand	☐ YES ☐ NO	☐ Home ☐ Work	
Knee	☐ YES ☐ NO	☐ Home ☐ Work	
Foot	☐ YES ☐ NO	☐ Home ☐ Work	

ORTHOPEDIC CARE & RESTRICTIONS

Have you ever had surgery on your back, neck, or other orthopedic surgery? ☐ YES ☐ NO

Date(s): _____ *Type of surgery:* _____

Are you currently taking any medication for a back, neck or other orthopedic injury? ☐ YES ☐ NO

Medication(s): _____

Are you currently under the care of a physician, physical therapist, chiropractor, or pain management specialist? ☐ YES ☐ NO

Provider name: _____ *Provider phone:* _____

Have you had any restrictions placed on you, current or past, due to a back, neck or other orthopedic injury? ☐ YES ☐ NO

Please list: _____

Have you experienced numbness or tingling, current or past, in your upper or lower extremities due to an injury? ☐ YES ☐ NO

Please explain: _____

I understand that failure to answer truthfully may result in the denial of compensation benefits, including medical treatment and expenses. I hereby certify that the information provided above and the information which I will provide to the medical provider in connection with this examination is true and correct to the best of my knowledge. I understand that any omission of fact or false statement is sufficient grounds for denial of employment or, if employed, termination of my employment.

EMPLOYEE SIGNATURE _____

DATE _____

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PATIENT ID / RECORD # _____

Medical Surveillance Questionnaire

FORM MC-113

Complete every section. Answer for your entire work history, not only your current employer.

FIRST NAME _____ LAST NAME _____ SSN / EMPLOYEE ID _____

DATE OF BIRTH _____ AGE _____ SEX ☐ Male ☐ Female TODAY'S DATE _____

EMPLOYER / COMPANY _____ JOB TITLE _____

OCCUPATIONAL & PAST WORK HISTORY

Worked with asbestos, silica, or other dusts	☐ YES	☐ NO
Worked with lead, cadmium, arsenic, or other metals	☐ YES	☐ NO
Worked with benzene, solvents, or degreasers	☐ YES	☐ NO
Worked with pesticides or herbicides	☐ YES	☐ NO
Worked with radiation or radioactive material	☐ YES	☐ NO
Worked in confined spaces	☐ YES	☐ NO
Regular exposure to loud noise at work	☐ YES	☐ NO
Currently required to wear a respirator	☐ YES	☐ NO
Previous workplace injury or illness claim	☐ YES	☐ NO

If yes, explain: _____

FAMILY HISTORY

Heart disease before age 55	☐ YES	☐ NO
High blood pressure	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
Lung disease	☐ YES	☐ NO
Kidney disease	☐ YES	☐ NO

If yes, explain: _____

RESPIRATORY

Shortness of breath walking on level ground	☐ YES	☐ NO
Chronic cough or coughing up phlegm	☐ YES	☐ NO
Wheezing or chest tightness	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Chronic bronchitis or emphysema (COPD)	☐ YES	☐ NO
Tuberculosis or positive TB test	☐ YES	☐ NO
Pneumonia in the last 12 months	☐ YES	☐ NO
Currently smoke or use tobacco	☐ YES	☐ NO

If yes, explain: _____

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PATIENT ID / RECORD # _____

Medical Surveillance Questionnaire

FORM MC-113

CARDIOVASCULAR

Chest pain or pressure with exertion	☐ YES	☐ NO
Heart attack, bypass, or stent	☐ YES	☐ NO
Irregular heartbeat or palpitations	☐ YES	☐ NO
High blood pressure	☐ YES	☐ NO
High cholesterol	☐ YES	☐ NO
Swelling in ankles or legs	☐ YES	☐ NO
Blood clot in the leg or lung	☐ YES	☐ NO

If yes, explain: _____

MUSCULOSKELETAL

Back injury or chronic back pain	☐ YES	☐ NO
Neck injury or chronic neck pain	☐ YES	☐ NO
Shoulder, elbow, wrist, or hand problems	☐ YES	☐ NO
Hip, knee, ankle, or foot problems	☐ YES	☐ NO
Arthritis or joint swelling	☐ YES	☐ NO
Hernia, current or repaired	☐ YES	☐ NO
Difficulty lifting, climbing, or prolonged standing	☐ YES	☐ NO

If yes, explain: _____

GASTROINTESTINAL

Frequent heartburn or reflux	☐ YES	☐ NO
Stomach or duodenal ulcer	☐ YES	☐ NO
Persistent nausea, vomiting, or abdominal pain	☐ YES	☐ NO
Blood in stool or black stools	☐ YES	☐ NO
Chronic diarrhea or constipation	☐ YES	☐ NO

If yes, explain: _____

HEPATOBILIARY & PANCREAS

Hepatitis A, B, or C	☐ YES	☐ NO
Jaundice or yellowing of skin or eyes	☐ YES	☐ NO
Gallbladder disease or gallstones	☐ YES	☐ NO
Pancreatitis	☐ YES	☐ NO
Abnormal liver function tests	☐ YES	☐ NO

If yes, explain: _____

CENTRAL NERVOUS SYSTEM

Seizures or epilepsy	☐ YES	☐ NO
Head injury with loss of consciousness	☐ YES	☐ NO
Frequent or severe headaches	☐ YES	☐ NO
Dizziness, fainting, or balance problems	☐ YES	☐ NO
Numbness, tingling, or weakness in arms or legs	☐ YES	☐ NO
Memory or concentration difficulty	☐ YES	☐ NO
Stroke or TIA	☐ YES	☐ NO

If yes, explain: _____

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PATIENT ID / RECORD # _____

Medical Surveillance Questionnaire

FORM MC-113

HEMATOLOGIC

Anemia or low blood count	☐ YES	☐ NO
Bleeding or clotting disorder	☐ YES	☐ NO
Blood transfusion	☐ YES	☐ NO
Enlarged lymph nodes	☐ YES	☐ NO

If yes, explain: _____

SKIN

Rash, dermatitis, or eczema	☐ YES	☐ NO
Chemical burn or skin reaction at work	☐ YES	☐ NO
Chronic skin infection or ulcer	☐ YES	☐ NO
Skin cancer or suspicious mole	☐ YES	☐ NO

If yes, explain: _____

HEENT - HEAD, EYES, EARS, NOSE, THROAT

Vision problems not corrected by glasses	☐ YES	☐ NO
Hearing loss or ringing in the ears	☐ YES	☐ NO
Ear drainage or frequent ear infections	☐ YES	☐ NO
Chronic sinus problems or nosebleeds	☐ YES	☐ NO
Hoarseness or difficulty swallowing	☐ YES	☐ NO

If yes, explain: _____

GENITOURINARY

Kidney stones or kidney disease	☐ YES	☐ NO
Blood in urine	☐ YES	☐ NO
Frequent urinary tract infections	☐ YES	☐ NO
Difficulty or pain with urination	☐ YES	☐ NO
Currently pregnant or possibly pregnant	☐ YES	☐ NO

If yes, explain: _____

EMPLOYEE ATTESTATION & ELECTRONIC SIGNATURE CONSENT

I certify that the answers above are true and complete to the best of my knowledge. I understand that withholding information may affect the accuracy of my medical clearance and my fitness for duty. I agree that signing this form electronically has the same force and effect as a handwritten signature, and I consent to conduct this transaction by electronic means.

EMPLOYEE SIGNATURE _____ DATE _____

PROVIDER REVIEW

FINDINGS / FOLLOW-UP REQUIRED

_____

PROVIDER SIGNATURE — ALEJANDRA FLORES, APRN, MSN, FNP-BC _____ DATE _____

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PATIENT ID / RECORD # _____

OSHA Respirator Medical Evaluation · Part A

FORM MC-105

TO THE EMPLOYER Answers to questions in Section 1, and 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 FOR EVERY EMPLOYEE SELECTED TO USE A RESPIRATOR

FIRST NAME _____ LAST NAME _____ SSN / EMPLOYEE ID _____

DATE OF BIRTH _____ AGE _____ SEX ☐ Male ☐ Female TODAY'S DATE _____

HEIGHT (FT / IN) _____ WEIGHT (LB) _____ CELL / HOME PHONE _____ BEST TIME TO REACH YOU _____

COMPANY _____ LOCATION / JOB # _____ YOUR JOB TITLE _____

Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ YES ☐ NO

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 (ex...half or full-facepiece type, powered-air purifying, supplied-air, (SCBA) self-contained breathing apparatus).

Have you ever worn a respirator? ☐ YES ☐ NO

If "YES", What type(s): _____

Have you ever <u>failed</u> a respirator examination or pulmonary function test? ☐ YES ☐ NO

If "YES", Why? _____

Have you ever been <u>denied</u> or <u>turned down</u> for the use of a respirator? ☐ YES ☐ NO

If "YES", Why? _____

PART A · SECTION 2 — MANDATORY

Questions 1 through 9 must be answered by every employee who has been selected to use any type of respirator.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? ☐ YES ☐ NO

If "YES", How long have you been smoking? _____ *Amount per day?* _____

What type of tobacco? (Check all that apply) ☐ Cigarettes ☐ Cigars ☐ Pipe tobacco

If "NO", Are you a former smoker? ☐ YES ☐ NO

How long ago did you quit? _____ *How long did you smoke?* _____ *Amount per day?* _____

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

Explain all "yes" answers in the space provided (Include dates and treatment)

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	

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

Explain all "yes" answers in the space provided (Include dates and treatment)

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	☐ YES ☐ NO	

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PATIENT ID / RECORD # _____

OSHA Respirator Medical Evaluation · Part A

FORM MC-105

FIRST NAME	LAST NAME	DATE OF BIRTH	TODAY'S DATE

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

Explain all "yes" answers in the space provided (Include dates and treatment)

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 you think may be related to lung problems	☐ YES ☐ NO	

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

Explain all "yes" answers in the space provided (Include dates and treatment)

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?

Explain all "yes" answers in the space provided (Include dates and treatment)

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 2 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 you think may be related to heart or circulation problems	☐ YES ☐ NO	

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

Explain all "yes" answers in the space provided (List medications and dosages)

A.	Breathing or lung problems	☐ YES ☐ NO	
B.	Heart trouble	☐ YES ☐ NO	
C.	Blood pressure	☐ YES ☐ NO	
D.	Seizures	☐ YES ☐ NO	

8. If you have used a respirator, have you ever had any of the following problems?

Explain all "yes" answers in the space provided

☐ Check if you have never used a respirator, then skip to question 9

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 your answers on this questionnaire? ☐ YES ☐ NO

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PATIENT ID / RECORD # _____

OSHA Respirator Medical Evaluation · Questions 10–15

FORM MC-105

FIRST NAME	LAST NAME	DATE OF BIRTH	TODAY'S DATE

MANDATORY for every employee selected to use a full-facepiece respirator or a self-contained breathing apparatus (SCBA).

VOLUNTARY for employees selected to use other types of respirators — answering questions 10–15 is optional.

10.	**Have you ever lost vision in either eye (temporarily or permanently)?**	☐ YES ☐ NO	
11.	**Do you currently have any of the following vision problems?**		
	Explain all "yes" answers in the space provided (Include dates and treatment)		
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 eardrum?**	☐ YES ☐ NO	
13.	**Do you currently have any of the following hearing problems?**		
	Explain all "yes" answers in the space provided (Include dates and treatment)		
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?**	☐ YES ☐ NO	
15.	**Do you currently have any of the following musculoskeletal problems?**		
	Explain all "yes" answers in the space provided (Include dates and treatment)		
A.	Weakness in any part 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	

PART B · DISCRETIONARY QUESTIONS

Any of these questions, and others not listed, may be added at the discretion of the reviewing health care professional.

1.	**In your present job, are you working at high altitudes (over 5,000 ft) 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?**	☐ YES ☐ NO	
	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?**		
	If "YES", Describe these exposures (Include dates and treatment)		
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 (e.g., mining)	☐ YES ☐ NO	
G.	Iron	☐ YES ☐ NO	
H.	Tin	☐ YES ☐ NO	
I.	Dusty environments	☐ YES ☐ NO	
J.	Any other hazardous exposures	☐ YES ☐ NO	
4.	**List any previous occupations:** _____		
5.	**List your current and previous hobbies:** _____		
6.	**List any second jobs or side businesses you have:** _____		

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OSHA Respirator Medical Evaluation · Part B

FORM MC-105

FIRST NAME | LAST NAME | DATE OF BIRTH | TODAY'S DATE

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
List the chemicals (if known): _____

8. **Have you ever worked on a HAZMAT team?** ☐ YES ☐ NO
If "YES", please list: _____

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)* ☐ YES ☐ NO
If "YES", Name the medications (if known): _____

10. **Will you be using any of the following items with your respirator(s)?**
- **A.** HEPA Filters ☐ YES ☐ NO
- **B.** Canisters (e.g., gas masks) ☐ YES ☐ NO
- **C.** Cartridges ☐ YES ☐ NO

11. **How often are you expected to use the respirator(s)?**
- **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 ☐ YES ☐ NO

12. **During the period you are using the respirator(s), is your work effort:**
- **A.** Light (less than 200 kcal per hour) ☐ YES ☐ NO
  If "YES", how long does this period last during the average shift: _____ hours _____ minutes
  ** Examples of light work effort: sitting while writing, typing, drafting, or performing light assembly work; standing while operating a drill press (1–3 lbs.) or controlling machines.*
- **B.** Moderate (200 to 350 kcal per hour) ☐ YES ☐ NO
  If "YES", how long does this period last during the average shift: _____ hours _____ minutes
  ** Examples of moderate work effort: 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) ☐ YES ☐ NO
  If "YES", how long does this period last during the average shift: _____ hours _____ minutes
  ** Examples of heavy work effort: 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.).*

13. **Will you be wearing protective clothing/equipment (other than the respirator) when you are using your respirator?** ☐ YES ☐ NO
If "YES", please describe this protective clothing and/or equipment: _____

14. **Will you be working under hot conditions?** *(Temperatures exceeding 77° Fahrenheit)* ☐ YES ☐ NO

15. **Will you be working under humid conditions?** ☐ YES ☐ NO

16. **Describe the work you will be doing while you are using your respirator(s):**

_____

_____

17. **Describe any special or hazardous conditions you might encounter when you are using your respirator(s)?**
(e.g., confined spaces, life-threatening gases):

_____

18. **Provide the following information** *(if known)* **for each toxic substance that you will be exposed to when you are using your respirator(s):**

A. 1st toxic substance *(name):* _____
Estimated max exposure level per shift: _____ Duration of exposure per shift: _____

B. 2nd toxic substance *(name):* _____
Estimated max exposure level per shift: _____ Duration of exposure per shift: _____

C. 3rd toxic substance *(name):* _____
Estimated max exposure level per shift: _____ Duration of exposure per shift: _____

D. List any other toxic substances that you will be exposed to while using your respirator: _____

19. **Describe any special responsibilities you will have while using your respirator that may affect the safety and well-being of others.**
(e.g., rescue, security):

_____

EMPLOYEE SIGNATURE _____ DATE _____

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Audiometry Questionnaire

FORM MC-111

PATIENT complete sections 1 through 6 and sign at the end of section 6. **TECHNICIAN** complete section 7 on the last page.

SECTION 1 · PATIENT INFORMATION

LAST NAME | FIRST NAME | MIDDLE NAME

EMPLOYEE NO OR SSN (LAST FOUR) | DATE OF BIRTH | NOISE EXPOSURE (DBA) | JOB TITLE

DATE OF TEST | TIME OF TEST | WORK LOCATION | DEPARTMENT | SHIFT LENGTH (HOURS)

SECTION 2 · PATIENT HISTORY

CONDITION	YES / NO	CONDITION	YES / NO
Cancer	☐ YES ☐ NO	High blood pressure	☐ YES ☐ NO
Chicken pox	☐ YES ☐ NO	Kidney disease	☐ YES ☐ NO
Chronic ear infections	☐ YES ☐ NO	Measles	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	Meningitis	☐ YES ☐ NO
Diphtheria	☐ YES ☐ NO	Scarlet fever	☐ YES ☐ NO
Ear drainage	☐ YES ☐ NO	Severe ringing in ears	☐ YES ☐ NO

SECTION 3 · CURRENT EAR STATUS

How your ears feel today, at the time of this test.

QUESTION	YES / NO / NOT SURE	IF YES, WHICH EAR?
Do you currently have ear discharge (liquid coming from your ear)?	☐ Y ☐ N ☐ Not sure	☐ Left ☐ Right ☐ Both
Do you currently have congestion (cold, flu, sinus)?	☐ Y ☐ N ☐ Not sure	☐ Left ☐ Right ☐ Both
Do you currently have ringing in your ears?	☐ Y ☐ N ☐ Not sure	☐ Left ☐ Right ☐ Both
Do you currently have ear pain, discomfort, or a feeling of fullness?	☐ Y ☐ N ☐ Not sure	☐ Left ☐ Right ☐ Both
Do you currently have an ear infection, or have you had multiple ear infections as an adult?	☐ Y ☐ N ☐ Not sure	☐ Left ☐ Right ☐ Both
Do you think your hearing has changed significantly since your last hearing test?	☐ Y ☐ N ☐ Not sure	☐ Left ☐ Right ☐ Both

SECTION 4 · HEARING HISTORY

Anything you have experienced in the past, at any point in your life.

QUESTION	YES / NO / NOT SURE	IF YES, WHICH EAR?
Have you ever been diagnosed with hearing loss, or do you have any known past hearing loss?	☐ Y ☐ N ☐ Not sure	☐ Left ☐ Right ☐ Both
Have you ever seen a doctor or other medical professional for ear or hearing problems?	☐ Y ☐ N ☐ Not sure	☐ Left ☐ Right ☐ Both
Has ear surgery ever been recommended or performed?	☐ Y ☐ N ☐ Not sure	☐ Left ☐ Right ☐ Both
Have you ever worn hearing aids?	☐ Y ☐ N ☐ Not sure	☐ Left ☐ Right ☐ Both
Do you currently have ear implants (cochlear implant, middle ear implant)?	☐ Y ☐ N ☐ Not sure	☐ Left ☐ Right ☐ Both
Have you ever had a burst or perforated eardrum as an adult?	☐ Y ☐ N ☐ Not sure	☐ Left ☐ Right ☐ Both
Have you ever had earwax removed by a professional?	☐ Y ☐ N ☐ Not sure	☐ Left ☐ Right ☐ Both
Have you been diagnosed with a physical ear abnormality (for example, no ear canal)?	☐ Y ☐ N ☐ Not sure	☐ Left ☐ Right ☐ Both
Have you ever had a head injury or loss of consciousness?	☐ Y ☐ N ☐ Not sure	☐ Left ☐ Right ☐ Both
Have you ever experienced frequent or severe dizziness?	☐ Y ☐ N ☐ Not sure	☐ Left ☐ Right ☐ Both
Have you had heavy use of “mycin” antibiotics, quinine, or aspirin?	☐ Y ☐ N ☐ Not sure	☐ Left ☐ Right ☐ Both
Any family history of hearing loss before age 50?	☐ Y ☐ N ☐ Not sure	☐ Left ☐ Right ☐ Both

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Audiometry Questionnaire

FORM MC-111

FIRST NAME	LAST NAME	DATE OF BIRTH	TODAY'S DATE

SECTION 5 · NOISE EXPOSURE & HEARING PROTECTION

WHEN WERE YOU LAST EXPOSED TO LOUD NOISE? ☐ Less than 1 hour ago ☐ 1 to 14 hours ago ☐ More than 14 hours ago

WERE YOU WEARING ADEQUATE HEARING PROTECTION DURING THAT EXPOSURE? ☐ Yes ☐ No ☐ Not applicable

WHAT HEARING PROTECTION DO YOU WEAR AT WORK? ☐ Earplugs ☐ Earmuffs ☐ Both ☐ None ☐ Other: _____

Have you ever served in the military?	☐ YES ☐ NO
Do you currently have a second job that is noisy?	☐ YES ☐ NO

NOISY HOBBIES

HOBBY	YES / NO	HOBBY	YES / NO
Car races	☐ YES ☐ NO	Power tools	☐ YES ☐ NO
Firearms	☐ YES ☐ NO	Woodworking	☐ YES ☐ NO
Motorcycling	☐ YES ☐ NO	Playing in a band	☐ YES ☐ NO

IF YOU USE FIREARMS, WHICH HAND PULLS THE TRIGGER? ☐ Left ☐ Right ☐ Not applicable

SECTION 6 · ANYTHING ELSE WE SHOULD KNOW

Note any other information relevant to this hearing test that you wish to share with the reviewing audiologist or physician.

PRINT PATIENT NAME	PATIENT SIGNATURE	DATE

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PATIENT ID / RECORD # _____

Audiometry Results

FORM MC-111

SECTION 7 · AUDIOMETRY RESULTS

Completed by the examining technician.

LAST NAME | FIRST NAME | MIDDLE NAME

EMPLOYEE NO OR SSN (LAST FOUR) | DATE OF BIRTH | NOISE EXPOSURE (DBA) | JOB TITLE

DATE OF TEST | TIME OF TEST | WORK LOCATION | DEPARTMENT | SHIFT LENGTH (HOURS)

UNABLE TO TEST DUE TO

☐ Wax buildup ☐ Possible infection ☐ Noise exposure within 14 hours ☐ Other: _____

CLINICIAN EVALUATION / NOTES

EAR EXAM (REQUIRED)	LEFT EAR	RIGHT EAR
Eardrum visible	☐ YES ☐ NO	☐ YES ☐ NO
Eardrum normal	☐ YES ☐ NO	☐ YES ☐ NO
Perforation	☐ YES ☐ NO	☐ YES ☐ NO
Other abnormality	☐ YES ☐ NO	☐ YES ☐ NO

AUDIOGRAM RESULTS	500 HZ	1000 HZ	2000 HZ	3000 HZ	4000 HZ	6000 HZ	8000 HZ
Left ear (dB)							
Right ear (dB)							

☐ Results attached Audiometer type: ☐ Microprocessor ☐ Manual Model: _____ Serial: _____

The technician named below has demonstrated competence in administering audiometric examinations, obtaining valid audiograms, and properly using, maintaining and checking the calibration of the audiometer used for this test, as required by 29 CFR 1910.95(g)(3).

PRINT EXAMINER / TECHNICIAN NAME | EXAMINER / TECHNICIAN SIGNATURE | DATE