

Department of Health Services

UNITED STATES MERCHANT MARINE ACADEMY
PATTEN HALL * KINGS POINT, NY * 11024-1699
Phone: 516-726-5680 * Fax: 516-773-5436 * Email: medical@usmma.edu

Respiratory Protection Medical Questionnaire Form

The purpose of this <u>required</u> 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: _	ftin. W	/eight:lbs.
Ethnicity: White Asian Black	Hispanic Native A	merican Other:
Have you worn a respirator before? Yes_	No	
If, "yes", what type(s):		
If applicable, describe the work you will be on how to fight fires onboard ship I will have to		i rator : <u>As part of my training</u>
If you know them, describe the possible ch	emicals, gases, dusts, or to	xic substances you might be
exposed to while wearing a respirator: As p	<u>part of Sea Year deployment re</u>	<u>equirements. I may be exposed</u>
to benzene/petroleum products/grain dust/othe	er particulates	
Do you currently smoke tobacco or have yo	ou smoked tobacco in the la	ast month? Yes No
List any medications you currently take: N	lame, dose, date prescribed.	
		_

Last name,	First name	

Mark "yes" or "no" (ANSWER ALL)	Υ	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 Characteristics (for a finish transfer of the state of the s		
Claustrophobia (fear of closed-in places)		
Trouble smelling odors		
Asbestosis		
Asthma		
Chronic bronchitis		
Have you <u>ever</u> had any of the following cardiovascular or heart symptoms?		
Mark "yes" or "no" (ANSWER ALL)	Y	Ν
Frequent pain or tightness in your chest		
Pain or tightness in your chest during physical		
activity		
Pain or tightness in your chest that interferes		
Pain or tightness in your chest that interferes with your job		
,		
with your job		
with your job In the past two years, have you noticed your		
with your job In the past two years, have you noticed your heart skipping or missing a beat		
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		
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		

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 following problems?	fthe	;
Mark "yes" or "no" (ANSWER ALL)	Y	N
Breathing or lung problems		
Heart trouble		
Blood pressure problems		

Last name,	First name			

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

Mark "yes" or "no" (ANSWER ALL)		Y	N
Loss of vision in either eye (temporarily or permane	ently)		
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):	_		
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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 backwar	rd 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 interfe	eres with using a respirator (specify):		
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