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Department 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 no later than May 30, 2025.

Date: _____

Last Name: _____ **First Name:** _____

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

Sex: 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?		
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 ever 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 currently 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 currently 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	☐	☐

Last name, First name _____

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

Have you ever 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 currently 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	☐	☐
Difficulty 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

Print Name

Signature of Parent/Legal Guardian for Minors Date

Print Name Relationship to Plebe Candidate