MEDICAL QUESTIONNAIRE

Name:_____ Date of Birth: _____

Dept/Office: _____ ID:_____

PAST MEDICAL HISTORY: Please indicate any medical condition that applies to you:

_____ High Blood Pressure	_____ Asthma	_____ Tuberculosis
_____ Angina (Heart pains)	_____ Emphysema	_____ Lung surgery
_____ Heart palpitations	_____ Chronic Bronchitis	_____ Seizures

_____ Other medical problems _____

Do you smoke? Yes/No How many years have you smoked? _____
How many packs smoked per day? _____

PLEASE CHECK ANY OF THE QUESTIONS THAT APPLY TO YOU:

1. Have you ever passed out during or after exercise or strenuous work?	Yes/No
2. Do you experience dizziness during or after exercise or strenuous work?	Yes/No
3. Have you ever had chest pain or tightness during or after exercise/work?	Yes/No
4. Do you cough or have trouble breathing during or after exercise/work?	Yes/No
5. Do you have a chronic, reoccurring cough?	Yes/No
6. Do you cough up phlegm or mucous most days of the week?	Yes/No
7. Are you currently taking medications for a heart problem or asthma?	Yes/No
8. Are you currently taking medications for high blood pressure?	Yes/No
9. Do you have any problems with your balance when you exercise/work?	Yes/No
10. Have you ever been treated for any lung problems?	Yes/No
11. Have you ever had a ruptured eardrum or other ear damage?	Yes/No
12. Has a doctor ever said that you should not exercise or do strenuous work?	Yes/No
13. Do you know any reason why you should not wear a respirator/mask?	Yes/No

EMPLOYEE CERTIFICATION:

I understand that this information will be provided only to appropriate medical personnel and employer designated supervisors. I certify that the information provided above is true and correct to the best of my knowledge.

_____ _____
Signature Date