COMPREHENSIVE HEALTH SERVICES, INC.

Exam Procedure	Procedure Name	Exam Id	Examinee Name
EQ103	WLFF TC SFF Health Questionnaire		

- Complete the Health Questionnaire prior to your exam appointment.
- Bring supporting medical documentation (if applicable) to any YES responses.
- Bring contact lenses or eyeglasses (if applicable) for the eye exam portion of exam.
- If you wear glasses or contacts ensure facility tests your vision both with and without you wearing them.
- Please bring photo ID to exam appointment.

1 - TUBERCULOSIS

1.	Have you ever had a skin test for TB?	☐Yes	☐No
	If yes, when: _____/_____/_____ (MM/DD/YYYY)		
2.	Have you ever had a positive TB skin test?	☐Yes	☐No
	If yes, did you take INH antibiotic for 3-6 months? ☐Yes ☐No		
3.	Have you ever been treated for active TB? (TB disease - more than just a positive skin test)?	☐Yes	☐No
4.	Have you had symptoms of TB within the last 6 months such as coughing up blood for 2-3 weeks, OR one or more of the following symptoms: chronic cough, chronic fatigue, fever >100, soaking night sweats, unexplained weight loss?	☐Yes	☐No

Please explain **ANY YES** answers to TB questions – include dates.

2 - Mental Health

1.	Have you had any hospitalizations or rehabilitation for mental health issues?	☐Yes	☐No
2.	Do you have anxiety, depression, panic disorder, or schizophrenia? (circle the ones that apply)	☐Yes	☐No
	If yes, is it: ☐ Current ☐ Ongoing ☐ Resolved more than one year ago		
3.	Do you have PTSD?	☐Yes	☐No
4.	Do you have claustrophobia or fear of heights? (circle the ones that apply)	☐Yes	☐No
5.	Do you have any mental health conditions requiring prescription medication?	☐Yes	☐No

Please explain **ANY YES** answers to mental health questions - include dates.

3 - Vision

1.	Do you wear corrective lenses?	☐Yes	☐No
2.	Do you wear contacts?	☐Yes	☐No
	If yes: ☐ Soft ☐ Hard ☐ Tinted		
3.	If required, will you carry a duplicate pair of corrective lenses or contact lenses while firefighting?	☐Yes	☐No
4.	Have you had any eye surgeries?	☐Yes	☐No

If yes check all that apply: ☐ Strabismus or Lazy Eye ☐ Glaucoma ☐ Retinal Detachment ☐ Lasik ☐ Trauma ☐ Other

Please explain **ANY YES** answers to vision surgeries questions - include dates.

5.	Are you color blind or do you have optic neuritis? (circle the ones that apply)	☐Yes	☐No
6.	Do you have night blindness, double vision or other visions issues? (circle the ones that apply)	☐Yes	☐No
7.	Do you have or have you ever had either partial or complete loss of vision?	☐Yes	☐No
	If yes: ☐ Right ☐ Left ☐ Both ☐ Fully recovered and stable OR ☐ Still a problem		
8.	Do you have difficulty sensing distance or problems with depth perception?	☐Yes	☐No

Please explain **ANY YES** answers to vision issue questions - include dates.

4 - Ears, Hearing, Nose, Throat

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1.	Do you have any type of ear disease or hearing loss?	☐Yes	☐No
	If yes:		
	Diagnosis:		
	Do you have difficulty hearing?	☐Yes	☐No
	Do you wear a hearing aid(s)?	☐Yes	☐No
	If yes (select one): ☐ Right ☐ Left ☐ Both		
2.	Do you get any ringing in the ear?	☐Yes	☐No
3.	Have you had any type of ear surgery?	☐Yes	☐No
4.	Do you use any type of protective hearing equipment when working around loud noises? If yes what type? ☐ Foam ☐ Pre-mold/plugs ☐ Ear muffs	☐Yes	☐No
5.	Are you in a hearing conservation program?	☐Yes	☐No
6.	Have you ever had an eardrum perforation?	☐Yes	☐No
7.	Do you have vertigo, dizziness, tinnitus (ringing in ears), or Meniere's disease? If yes, check all that apply: ☐ Vertigo ☐ Dizziness ☐ Tinnitus (ringing in ear) ☐ Meniere's disease	☐Yes	☐No
8.	Do you have a cochlear implant? If yes: (select one): ☐ Right ☐ Left ☐ Both	☐Yes	☐No
9.	Do you have nosebleeds (recurrent or severe - requiring medical care)?	☐Yes	☐No
10.	Do you have tumors or polyps?	☐Yes	☐No
11.	Do you have Allergic Rhinitis?	☐Yes	☐No
12.	Have you had ear/nose/throat surgery, other than minor or childhood?	☐Yes	☐No
13.	Do you have dental problems, gingivitis, or oral appliances?	☐Yes	☐No

Please explain ANY **YES** answers to any Ears, Hearing, Nose, Throat questions – include dates.

5 - Skin

1.	Do you have skin cancer?	☐Yes	☐No
	a. If yes check all that apply: ☐ Basal ☐ Squamous Cell ☐ Melanoma (ever) b. What is the current state of the cancer? ☐ Resolved ☐ Ongoing treatments	☐Yes	☐No
2.	Do you have albinism or other genetic conditions?	☐Yes	☐No
3.	Do you have eczema, psoriasis, contact dermatitis or allergic dermatitis? (circle all that apply)	☐Yes	☐No
4.	Do you have folliculitis or cystic acne?	☐Yes	☐No
5.	Do you have cysts or abscesses requiring surgery?	☐Yes	☐No
6.	Do you have urticarial, hives or scleroderma? (circle all that apply)	☐Yes	☐No

Please explain **ANY YES** answers to skin questions – include dates.

6 - Lungs - Do you have or have you ever had any of the following?

1.	Shortness of breath, wheezing or persistent cough (circle all that apply)	☐Yes	☐No
2.	Asthma, COPD, emphysema, chronic bronchitis (circle all that apply)	☐Yes	☐No
3.	Lung cancer	☐Yes	☐No
4.	Sarcoidosis	☐Yes	☐No
5.	Pulmonary embolism (clot in lungs)	☐Yes	☐No
6.	Collapsed lung	☐Yes	☐No

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7. Pulmonary hypertension	☐Yes	☐No
8. Lung Surgery	☐Yes	☐No
9. Loud snoring or pauses in breathing while asleep	☐Yes	☐No
10. Fall asleep easily during the day	☐Yes	☐No
11. Sleep disorder, sleep apnea, narcolepsy or ever advised to use CPAP (circle all that apply)	☐Yes	☐No

If yes, ☐**I have attached a copy of my most recent sleep study and/or CPAP compliance report**

Please explain **ANY YES** answers to lung questions – include dates.
☐** I have attached a copy of my most recent spirometry or PFT, if available. **

7 - Heart – Do you have or have you ever had any of the following?

1. Heart attack or angina	☐Yes	☐No
2. Chest pain or tightness	☐Yes	☐No
3. Congestive heart failure	☐Yes	☐No
4. Cardiomyopathy	☐Yes	☐No
5. Heart block	☐Yes	☐No
6. Pacemaker or ICD	☐Yes	☐No
7. Bypass or valve surgery	☐Yes	☐No
8. Angioplasty or stent	☐Yes	☐No
9. Murmur	☐Yes	☐No
10. Irregular heartbeat, palpitations, or arrhythmias (circle all that apply)	☐Yes	☐No
11. Abnormal electrocardiogram (ECG)	☐Yes	☐No

Please explain **ANY YES** answers to heart questions – include dates.

8 - Hypertension (High Blood Pressure)

1. Have you ever been diagnosed with hypertension?	☐Yes	☐No
2. Have you ever had hypertension requiring prescription medication?	☐Yes	☐No
3. Have you ever required hospitalization due to hypertension?	☐Yes	☐No
4. Do you have complications (kidneys, heart, brain, circulation, eyes) (circle all that apply)	☐Yes	☐No

Please explain **ANY YES** answers to hypertension questions – include dates.

9 - Vascular (Clots, Circulation) - Do you have or have you ever had any of the following?

1. Peripheral artery disease	☐Yes	☐No
2. Aneurysm	☐Yes	☐No
3. Varicose veins requiring stockings or surgery	☐Yes	☐No
4. Phlebitis, deep vein thrombosis, or clots in legs or lungs (circle all that apply)	☐Yes	☐No
5. Ever been on a blood thinner (Coumadin® or Warfarin, Heparin, Xarelto®)	☐Yes	☐No
6. Raynaud's Disease	☐Yes	☐No
7. Leg cramps in buttock, thigh, or calf	☐Yes	☐No
8. Vasculitis	☐Yes	☐No

Please Explain **ANY YES** answers to vascular questions – include dates.

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10 - Gastrointestinal (Stomach, bowels) – Do you have or have you ever had any of the following?		
1. Crohn's disease, ileitis, ulcerative colitis, other colitis (circle all that apply)	☐Yes	☐No
2. Colostomy or ileostomy (circle all that apply)	☐Yes	☐No
3. Diverticulitis, chronic or recurrent	☐Yes	☐No
4. Irritable bowel syndrome	☐Yes	☐No
5. Cholecystitis (gallbladder), chronic or recurrent	☐Yes	☐No
6. Pancreatitis	☐Yes	☐No
7. Bleeding in the stomach or bowels	☐Yes	☐No
8. Blood in stool or vomited blood	☐Yes	☐No
9. Ulcers	☐Yes	☐No
10. Surgery (gastrointestinal)	☐Yes	☐No
11. Cancer (gastrointestinal)	☐Yes	☐No
12. Any dietary intolerance, special diet, or food allergy?	☐Yes	☐No
Please explain **ANY YES** answers to gastrointestinal questions – include dates.		
11- Liver		
1. Have you ever had hepatitis from any cause?	☐Yes	☐No
2. Do you have cirrhosis?	☐Yes	☐No
3. Have you ever had jaundice (yellow skin) other than infancy?	☐Yes	☐No
12 - Hernias – Do you have or have you ever had any of the following?		
1. Inguinal (groin); surgery advised or have had surgery	☐Yes	☐No
2. Abdominal (ventral or umbilical); surgery advised or have had surgery	☐Yes	☐No
3. Femoral; surgery advised or have had surgery	☐Yes	☐No
13 - Urinary (kidney, ureter, or bladder) – Do you have or have you ever had any of the following?		
1. Renal (kidney) failure	☐Yes	☐No
2. Dialysis	☐Yes	☐No
3. Difficulty passing urine	☐Yes	☐No
4. Frequent urinating (more than once an hour)	☐Yes	☐No
5. Nocturia or need to void at night	☐Yes	☐No
6. Surgery or missing kidney (circle all that apply)	☐Yes	☐No
7. Recurrent urine infections	☐Yes	☐No
8. Kidney stones	☐Yes	☐No
9. Excess urine protein or Nephrotic syndrome	☐Yes	☐No
Please explain **ANY YES** answers to liver, hernias, or urinary questions – include causes and dates.		
14 - Extremities (arms, legs) Do you have or have you ever had any of the following?		
1. Amputation or prosthesis	☐Yes	☐No
2. Other orthopedic surgery	☐Yes	☐No
3. Deformity or chronic pain	☐Yes	☐No
15 - Neck or Spine – Do you have or have ever you had any of the following?		

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1.	Neck or spine surgery	☐Yes	☐No
2.	Fractures	☐Yes	☐No
3.	Chronic back or neck pain or loss of motion	☐Yes	☐No
4.	Require assistive device with cane, crutches, walker, or wheelchair	☐Yes	☐No
5.	Herniated disc	☐Yes	☐No
6.	Scoliosis	☐Yes	☐No

Please explain **ANY YES** answers to neck or spine questions – include dates.

16 - Joints or Arthritis – Do you have or have you ever had any of the following?

1.	Any kind of arthritis (rheumatoid, degenerative, gout, etc.)	☐Yes	☐No
2.	Joint pain or swelling, loss of motion	☐Yes	☐No
3.	Rotator cuff problems (shoulder)	☐Yes	☐No
4.	Surgery or joint replacement	☐Yes	☐No

Please explain **ANY YES** answers to joint or arthritis questions – include dates.

17 - Neurological (Brain, Nerves) – Do you have or have you ever had any of the following?

1.	Seizures or epilepsy	☐Yes	☐No
2.	Brain or skull surgery	☐Yes	☐No
3.	Concussion or loss of consciousness from hitting head	☐Yes	☐No
	If yes, ☐ Over one year ago, fully recovered ☐ Less than one year ago		
4.	Syncope or fainting	☐Yes	☐No
5.	Bleeding in brain	☐Yes	☐No
6.	Stroke or TIA	☐Yes	☐No
7.	Problem with dizziness, balance or coordination (circle all that apply)	☐Yes	☐No
8.	Numbness or tingling in hands or feet	☐Yes	☐No
9.	Difficulty sensing hot or cold with hands or feet	☐Yes	☐No
10.	Weakness in arms or legs	☐Yes	☐No
11.	Peripheral neuropathy from any cause	☐Yes	☐No
12.	Multiple sclerosis	☐Yes	☐No
13.	Muscular dystrophy	☐Yes	☐No
14.	Migraines	☐Yes	☐No
15.	Cancer (brain)	☐Yes	☐No

Please explain **ANY YES** answers to neurological (brain, nerves) questions – include dates.

18 - Endocrine (diabetes, thyroid, etc.) – Do you have or have you ever had any of the following?

1.	Diabetes or elevated blood sugar	☐Yes	☐No
2.	Thyroid gland disorder	☐Yes	☐No
3.	Adrenal or pituitary gland disorder	☐Yes	☐No
4.	Low blood sugar or hypoglycemia	☐Yes	☐No

Please explain **ANY YES** answers to endocrine questions - include dates.

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19 - Hematologic or Blood Immune System – Do you have or have you ever had any of the following?		
1. Anemia	☐Yes	☐No
2. Leukemia	☐Yes	☐No
3. Low platelets	☐Yes	☐No
4. Bleeding disorder or coagulopathy, including Hemophilia	☐Yes	☐No
5. Easy bruising	☐Yes	☐No
6. Sickle Cell disease or trait, other hemoglobin variant (circle all that apply)	☐Yes	☐No
7. Enlarged spleen or splenectomy	☐Yes	☐No
8. Immune disorder or infection, including HIV	☐Yes	☐No
9. Myasthenia Gravis	☐Yes	☐No
10. Lupus	☐Yes	☐No
11. Vaccine or immunization intolerance or allergy	☐Yes	☐No
12. Hereditary angioedema	☐Yes	☐No
Please explain **ANY YES** answers to hematologic questions - include dates.		

20 - Females Only Do you have or have you ever had any of the following?		
1. Severe Menstrual Cramps or Heavy Bleeding	☐Yes	☐No
2. Chronic Pelvic or Abdominal Pain	☐Yes	☐No
3. Gynecological Surgery	☐Yes	☐No
4. Gynecological Cancer	☐Yes	☐No
5. Ectopic pregnancy	☐Yes	☐No
Please explain **ANY YES** answers – include dates.		

21 - Males Only - Do you have or have you ever had any of the following?		
1. Prostate disease or cancer	☐Yes	☐No
2. Testicular torsion or cancer	☐Yes	☐No
Please explain **ANY YES** answers – include dates.		

22 - Medications		
1. Do you currently use an inhaler?	☐Yes	☐No
If yes, check all that apply: ☐ Asthma or COPD ☐ Occasional bronchitis (less than once a year) ☐ Exercise ☐ Allergies		
If yes, do you carry it during firefighting?	☐Yes	☐No
If yes, please explain:		
2. List all current medications and reason for taking.		
3. Do you take anabolic steroids or growth hormones?	☐Yes	☐No
If yes, please explain:		

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4. Do you take over the counter medications, supplements, or herbal medications? Check all that apply.				☐Yes ☐No
☐Antihistamine or allergy	☐Sedative for sleep	☐Smoking cessation		
☐Stimulant	☐Anxiety, etc.	☐Weight loss	☐Other	
If yes, please explain:				
5. Do you experience any side effects from any medication?				☐Yes ☐No
If yes, please explain:				
23 - Tobacco Use – If yes check all that apply.				☐Yes ☐No
☐ **Cigarettes:** Packs per day_____ X _____years				
☐ **eCigarettes:** Per day _____				
☐ **Cigars:** Per day _____ **X** _____ years				
☐ Other tobacco products, chew or snuff				
24 - Alcohol and Drug Use				
1. Do you drink alcohol?				☐Yes ☐No
If yes, please provide the average number of drinks per week _____				
2. Have you had or do you have alcoholism, drug or alcohol dependency or abuse (circle all that apply)?				☐Yes ☐No
3. Do you use illegal drugs?				☐Yes ☐No
4. Are you currently using someone else's prescription medication?				☐Yes ☐No
Please explain **ANY YES** answers to alcohol or drug questions – include dates.				
25 - Allergy (medication, bees, other)				☐Yes ☐No
Name and reaction:				
☐ Ever been advised to carry an Epi-Pen				☐Yes ☐No
☐ Ever required medical care or hospitalization for allergic reaction in the past				☐Yes ☐No
☐ Currently advised to carry an Epi-Pen or epinephrine injector for allergic reactions				☐Yes ☐No
26 - Surgery or Hospitalization				☐Yes ☐No
If yes, please provide reason and year:				
Any health changes since last medical evaluation or exam?				☐Yes ☐No
If yes, please explain:				
Ever received a permanent disability rating?				☐Yes ☐No
If yes, please explain:				
Do you have an active workers' compensation claim related to a work-related injury, illness, or exposure?				☐Yes ☐No
If yes, please explain:				
Do you have current medical or physical work restrictions?				☐Yes ☐No

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If yes, please explain:

I hereby certify that the above answers are complete and accurate to the best of my knowledge.

_____ _____ _____

Examinee Name (Please Print) **Signature** **Date**