Service Date:

Concentra Medical Centers (MD)
4451 Parliament Place Ste F Lanham, MD 20706
Phone: (301) 459-9117 Fax: (301) 459-1478

Firefighter Examination

Patient: **Address:** **Employer:**
SSN: **Address:**
DOB: **Phone:**

☐ BASELINE ☐ PERIODIC EXAM ☐ EXIT

☐ MALE ☐ FEMALE

Have you ever had or been treated for any of the following? (Explain all yes answers below)

Y N Organ transplant	Y N Glaucoma / cataracts	Y N Heart attack
Y N Prosthetic device	Y N Ear disease or injury	Y N Abnormal heart rhythm
Y N Implanted pump (ex: insulin)	Y N Difficulty hearing/ hearing loss	Y N Cardiac stent or angioplasty
Y N Electrical device	Y N Asthma or wheezing	Y N Other heart problem or disease
Y N Advised to have an operation	Y N Emphysema or COPD	Y N Heart surgery
Y N Hospitalized	Y N Positive test for tuberculosis	Y N High blood pressure
Y N Alcohol dependence	Y N Shortness of breath	Y N Palpitations
Y N Illegal drugs/ drug abuse	Y N Cough lasting more than 2 mo.	Y N Heart Attack
Y N Applied for disability	Y N Other lung disease or surgery	Y N Heart Block
Y N Convulsions, seizures, epilepsy	Y N Excessive / unexplained fatigue	Y N Pacemaker
Y N Concussion or head injury	Y N Use of inhalers	Y N Defibrillator
Y N Frequent headaches	Y N Acute or chronic lung infection	Y N Heart rhythm disturbances
Y N Dizziness or vertigo	Y N Collapsed lung	Y N Vascular disease
Y N Fainting or unconsciousness	Y N Scoliosis	Y N Enlarged veins
Y N Color vision problems	Y N History of tuberculosis	Y N History of blood clots
Y N Eye disease or injury	Y N Chest pain	Y N Anemia
Y N Blurred vision	Y N Heart murmur	Y N Hardening of the arteries
Y N Liver disease or hepatitis	Y N Seizures (current or previous)	Y N Infertility
Y N Unusual bleeding	Y N Spinal cord injury	Y N Musculoskeletal disease
Y N Hernias	Y N Positive test for tuberculosis	Y N Amputations
Y N Colostomy	Y N Head/ spine surgery	Y N Moderate/severe joint pain
Y N Irritable bowel syndrome	Y N History of head trauma	Y N Loss of use of arm/leg
Y N Rectal bleeding	Y N Stroke	Y N Loss of coordination
Y N Kidney disease	Y N Transient Ischemic attack	Y N Chronic back pain
Y N Protein/blood/sugar in urine	Y N Aneurysms	Y N Back or neck surgery
Y N Kidney stones	Y N Poor circulation to hands& feet	Y N Moderate / severe arthritis
Y N Sleep apnea/ sleep disorder	Y N Chronic/ recurring headaches	Y N Herniated disc or sciatica
Y N Muscle weakness	Y N Brain tumor	Y N Chronic skin rash or disease
Y N Blood disorder	Y N Loss of memory	Y N Sun sensitivity
Y N Head / Cranial surgery	Y N Any endocrine disease	Y N Moles that have changed
Y N Brain tumor	Y N Diabetes	Y N Depression or anxiety
Y N Cancer	Y N Thyroid disease	Y N Insomnia
Y N Numbness or tingling	Y N Unexplained weight loss/gain	Y N Any other mental condition
Y N Tremors	Y N Obesity	Y N Any other illness or condition

Patient: **DOB:** **Service Date:**

Please explain the details of all yes answers from the previous page and include any treatment you may have had:

____

____

____

____

____

____

____

Surgeries (with dates performed): ____

____

Personal History:

- Have you ever smoked: __ Cigarettes __Cigar __ Pipe Do you smoke now? Y N Age started: ________
- If you have stopped smoking, how old were you when stopped? ____________
- How many packs do you smoke or have smoked per day? ____________
- Do you or have you ever drunk alcoholic beverages? Y N Age started: ______ Age stopped: ______
- Average numbers of alcoholic beverages per week: Beer _______oz Wine: ______ oz/glass Drinks: _____ oz
- Do you or have you ever used illegal drugs? Y N

Physical activity/ Exercise: Type / duration / frequency: ____

____

Medications: (including prescriptions, over the counter, supplements): ____

____

Allergies: ____

Incomplete forms or missing information may result in a delay clearing you for firefighter duties. Submitting information that is misleading or untruthful may result in termination, criminal sanctions, or failure to be cleared for duty. This history form and review does not substitute for routine health care or a periodic health examination conducted by your physician. It is being conducted for occupational purposes only.

I certify that all the information I have provided on this form is complete and accurate to the best of my knowledge

Applicant's signature: ______________________________ Date: ______________

Clinician's comments: ____

____

Concentra®

Concentra Medical Centers (MD)
4451 Parliament Place Ste F Lanham, MD 20706
Phone: (301) 459-9117 Fax: (301) 459-1478

Service Date: ____________

TB Screening
Detección de Tuberculosis

Patient Name: ______________________ Date of Birth: ______________________ Employer Name: ____________________

			Initial Visit Current Symptom Screen Please answer the questions below for your TB screening visit.	**Consulta Inicial Para Evaluación De Síntomas Actuales** Responda las preguntas de abajo para su consulta de evaluación de tuberculosis (TB).
		1.	Do you currently have ANY of the following symptoms?	¿Tiene actualmente ALGUNO de estos síntomas?
YES	NO		• Cough lasting for more than 3 weeks	• Tos que dura más de 3 semanas
YES	NO		• Coughing or spitting up blood	• Tos con sangre o escupe sangre
YES	NO		• Unexplained weight loss	• Pérdida de peso inexplicable
YES	NO		• Drenching night sweats or fever for more than 2 weeks	• Sudoración nocturna intensa o fiebre por más de 2 semanas
YES	NO		• Loss of appetite for more than 2 weeks	• Pérdida del apetito por más de 2 semanas
YES	NO		• Hoarseness	• Ronquera
YES	NO		• Chest pain	• Dolor en el pecho
YES	NO	2.	Have you had a prior POSITIVE TB Skin test or POSITIVE TB Blood test? If YES, please provide us with a copy of that documentation and the following information: **Date of positive TST or T-Spot (IGRA):** __________ **Date of last chest X-ray:** ___________	¿Ha tenido un resultado POSITIVO para TB de una prueba cutánea o de un análisis de sangre? Si la respuesta es "Sí", denos una copia de esa documentación y la siguiente información: **Fecha de la prueba cutánea de tuberculina (tuberculin skin test, TST) o T-Spot (IGRA) positiva:** __________ **Fecha de la última radiografía de tórax:** ___________
YES	NO	3.	Have you been treated for tuberculosis with medications such as INH?	¿Alguna vez ha recibido tratamiento para la tuberculosis con medicamentos como INH?
YES	NO	4.	Are you here to repeat your TB blood test because your previous test was borderline or invalid?	¿Está aquí para repetir la prueba de TB porque la prueba anterior fue dudosa o inválida?
YES	NO	5.	Have you received a vaccine in the past 4 weeks?	¿Ha recibido alguna vacuna en las últimas 4 semanas?
YES	NO	6.	Have you lived or traveled for more than 1 month in a country with a high TB rate? (Any country other than United States, Canada, Australia, New Zealand, and countries in Northern Europe or Western Europe).	¿Ha vivido o estado durante más de 1 mes en un país que tenga una tasa alta de TB? (Cualquier país que no sea Estados Unidos, Canadá, Australia, Nueva Zelanda y países del norte u oeste de Europa).
YES	NO	7.	Are you currently immunosuppressed (immunocompromised) or have planned immunosuppression? This includes HIV infection, organ transplant recipient, treatment with TNF-alpha antagonist (e.g., infliximab, etanercept, or other) chronic steroids (equivalent of prednisone ≥ 15 mg/day for ≥ 1 month) or other immunosuppressive medication.	¿Está actualmente inmunodeprimido (inmunodeficiente) o tiene alguna inmunodepresión planificada? Esto incluye infección por VIH, ser receptor de un trasplante de órgano, recibir tratamiento con antagonistas del TNF-alfa (por ejemplo, infliximab, etanercept u otros), esteroides crónicos (equivalente a prednisone ≥ 15 mg/dia durante ≥ 1 mes) u otro medicamento inmunosupresor.
YES	NO	8.	Have you had close contact with someone who has had infectious TB disease since your last TB test?	¿Ha tenido contacto cercano con alguien que ha tenido enfermedad infecciosa de TB desde su última prueba de TB?
YES	NO	9.	Have you had a severe reaction to the TB skin test, such as ulceration/open weeping sores or anaphylactic shock/hospitalization?	¿Tuvo alguna reacción grave a la prueba cutánea de TB, como alguna ulceración/llagas abiertas exudativas, o algún choque anafiláctico/hospitalización?
YES	NO	10.	Have you ever received the BCG vaccine?	¿Ha recibido la vacuna contra la tuberculosis (BCG)?
			Explain any YES answers:	Explique las respuestas afirmativas:

Signature of Patient/Guardian: ______________________ **Date:** __________
Firma del paciente/tutor **Fecha**

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CMBNTUB -1

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Date: 07/20/2021 ______ Chart #: ______

Age ______ Birth Sex: ______ SSN: ______ ______

Name: ______ Job Title: ______

Employer Name: ______ Department: ______

TO THE EMPLOYER

Answers to questions in Section 1, and to question 9 in section 2 of part A, do not require a medical examination. However, it does require that a Physician or Licensed Health Care Professional (PLHCP) review this questionnaire and answer any questions you may have concerning the questions asked in this questionnaire.

TO THE EMPLOYEE

Can you read? (Circle one) Yes No

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.

TO THE PHYSICIAN OF OTHER LICENSED HEALTH CARE PROFESSIONAL (PLHCP)

Review Part A Sections 1 and 2. When an employee answers YES to any of the questions in Section 2 and the questionnaire is not administered in conjunction with a physical examination, the employee needs to be considered for a follow-up physical examination with particular emphasis on those areas in which the employee answered YES. When an employee answers YES to any of the questions in Section 2 and this questionnaire is completed in conjunction with a physical examination, the physician will place particular emphasis upon those areas to which the employee answered YES. In either situation the PLHCP will complete the "PLHCP's Written Statement" to both the employee and employer **within 2 days.**

PART A SECTION 1 (MANDATORY)

The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Your height: ______ ft. ______ in.
2. Your weight: ______ lbs.
3. Your job title: ______
4. A phone number where you can be reached by the health care professional who will review this questionnaire (include area code): ______
5. The best time to phone you at this number is: ______ am/ ______ pm.
6. Has your employer told you how to contact the health care professional who will review this questionnaire? (circle one): Yes No
7. 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 (for example, half - or full-facepiece type, powered - air purifying, supplied - air, self-contained breathing apparatus).
8. Have you worn a respirator (circle one): Yes No
   If "Yes", what type(s): ______

TO BE FILED IN EMPLOYEE'S MEDICAL FILE

PART A SECTION 2 (MANDATORY)
Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. (please circle "Yes" or "No").

1. Yes No **Do you currently smoke tobacco, or have you smoked tobacco in the last month?**

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

Yes No a. Seizures (fits)
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

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

Yes No 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

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

Yes No a. Shortness of breath
Yes No b. Shortness of breath when walking 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 that you think may be related to lung problems

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

Yes No 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
Yes No g. High blood pressure
Yes No h. Any other heart problem that you've been told about

6. Have you ever had any of the following cardiovascular or heart symptoms?

Yes No 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 two 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 that you think might be related to heart or circulation problems

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

Yes No a. Breathing or lung problems
Yes No b. Heart trouble
Yes No c. Blood pressure
Yes No d. Seizures (fits)

8. If you've used a respirator, have you ever had any of the following problems?
(If you've never used a respirator, check the following space ___________ and go to question 9)

Yes No 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 problems that interfere with your use of a respirator

9. Yes No **Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?**

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Yes No **Have you ever lost vision in either eye (temporarily or permanently)**

11. Yes No **Do you currently have any of the following vision problems?**

Yes No a. Wear contact lenses
Yes No b. Wear glasses
Yes No c. Color blindness
Yes No d. Any other eye or vision problems

12. Yes No **Have you ever had an injury to your ears, including a broken ear drum?**

13. **Do you currently have any of the following hearing problems?**

- Yes No a. Difficulty hearing
- Yes No b. Wear a hearing aide
- Yes No c. Any other hearing or ear problems

14. Yes No **Have you ever had a back injury?**

15. **Do you currently have any of the following musculoskeletal problems?**

- Yes No a. Weakness in any 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.

TO THE PLHCP

Check ✓ the ONE that applies

☐ I have reviewed Part A Section 2 of this questionnaire with the employee and I do not recommend that a physical examination be performed.

☐ I have reviewed Part A Section 2 of this questionnaire with the employee and I am recommending that a physical examination be performed.

☐ I have reviewed Part A section 2 of this questionnaire without the employee and I do not recommend that a physical examination be performed.

☐ I have reviewed Part A Section 2 of this question without the employee and I am recommending that a physical examination be performed.

____
PLHCP Signature

____
Employee Signature
(When Available)

____
Date

TO BE FILED IN EMPLOYEE'S MEDICAL FILE

Concentra Medical Centers (MD)
4451 Parliament Place Ste F Lanham, MD 20706
Phone: (301) 459-9117 Fax: (301) 459-1478

Service Date:

Audiometric Examination

Patient:
SSN:
DOB:

Address:

Phone:

Employer:
Address:

MEDICAL HISTORY
(ANTECEDENTES MEDICOS)
Have you ever had:
(Ha tenido o padecido alguna vez de):

___Mumps
(Paperas)
___Measles
(Measles)
___Diabetes
(Diabetes)
___High fever
(Fiebres Altas)
___Meningitis
(Meningitis)
___High blood pressure
(Alta presion)
___Allergies
(Alergias)
___Ear infections
(Infecciones en los oidos)
___Perforation of ear drum
(Perforacion del timpani)
___Drainage from ear
(Secreciones en los oidos)

___Ringing in ears
(Campaneo en los oidos)
___Dizziness
(Mareos)
___Severe head injury
(Algun golpe severo en la cabeza)
___Arthritis
(Artritis)
___Recent sinus problems
(Problemas recientes con su nariz)
___Diagnosed hearing loss
(Se la ha diagnosticado de perdida de oir)
___Wear a hearing aid
(Usa dispositivo audito)

NON-OCCUPATIONAL HISTORY
(ANTECEDENTES NO LABORALES)
Have you ever been exposed to:
(Ha estado alguna vez expuesto a:

___Loud music
(Musica muy alta)
___Power tools
(Herramientas de alta potencia)
___Motorcycles
(Motocicletas)
___Farm tractors, machinery
(Tractores agrícolas, maquinaria)
___Military Service
(Servicio Militar)
Which branch of military ________________
(Cual rama de las fuerzas armadas?)________________

___Chain saws
(Sierras de cadena)
___Drag racing
(Carrera de carros)
___Car engines
(Motores de automóviles)
___Gun fire
(Disparos de armas)

OCCUPATIONAL HISTORY
(ANTECEDENTES LABORALES)
___Use hearing protection
(Ha usando alguna vez proteccion para oidos)
___ Plugs ___Muffs

Have you been exposed to loud noises where you must shout to be heard in conversation **without** hearing protection in the last 14 hours?* (Ha estado expuesto al ruido duranted las ultimas 14 horas?)
Yes ___ No____

________________________________ Date________________
Employee Signature

All questions above have been answered by the employee Yes____ No ____

________________________________ Date________________
MSS Signature

Audiometry performed by ________________ ________________ Date ____________
Print Name Sign Name

*If employee answered yes, hearing loss may be over-reported on the audiogram, and a repeat audiogram as soon as possible is recommended after refraining from noise exposure for 14 hours.