

ARKANSAS FORESTRY COMMISSION
HEALTH HISTORY QUESTIONNAIRE

To the employee: Please read the following before completing questions below.

Can you read (circle one): Yes / No

Andrew Prychodko, M.D. will review this questionnaire. AFC personnel will not read your questionnaire. The questionnaire is confidential and remains on file with Dr. Prychodko. To contact Dr. Prychodko, please call the AFC Personnel Manager for contact information.

The AFC will 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.

Please retain this questionnaire after completed until a qualified AFC employee takes the clinical readings listed on page five of this questionnaire. Dr. Andrew Prychodko will review the questionnaire.

Part A. Section 1. (Mandatory) The following information must be provided by every Arkansas Forestry Commission Firefighter. (Please print)

1. Today's date: _____
2. Your name: _____
3. Your age (to nearest year): _____
4. Sex (circle one): Male / Female
5. Your height: ____ft. ____in.
6. Your weight: ____lbs.
7. Your job title: _____
8. A phone number where you can be reached by Dr. Prychodko who will review this questionnaire (include Area Code): (____) ____-_____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact Dr. Prychodko who will review this questionnaire (circle one): Yes / No

11. Have you worn a respirator (circle one): Yes / No

If "yes," what type(s): _____

Part A. Section 2. (Mandatory) Questions 1 through 8 below must be answered by every Arkansas Forestry Commission firefighter. (please circle "yes" or "no").

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

2. Have you ever had any of the following conditions?
 - 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: Yes / No

3. Have you ever had any of the following pulmonary or lung problems?
 - 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 problems that you've been told about: Yes / No

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
 - a. Shortness of breath: Yes / No
 - b. Shortness of breath when walking fast 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: Yes / No
5. Have you ever had any of the following cardiovascular or heart problems?
- 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 (heart beating irregularly): Yes / No
 - g. High blood pressure: Yes / No
 - h. Any other heart problem that you've been told about: Yes / No
6. Have you ever had any of the following cardiovascular or heart symptoms?
- 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: Y/N
 - e. Heartburn or indigestion that is not related to eating: Yes / No
 - f. Any other symptoms that you think may be related to heart or circulation problems: Yes / No
7. Do you currently take medication for any of the following problems?
- a. Breathing or lung problems: Yes / No
 - b. Heart trouble: Yes / No
 - c. Blood pressure: Yes / No
 - d. Seizures (fits): Yes / No

Part B. Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of Dr. Prychodko who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes / No
2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes / No

If "yes," name the chemicals if you know them: _____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

- a. Asbestos: Yes / No
- b. Silica (e.g., in sandblasting): Yes / No
- c. Tungsten/Cobalt (e.g., grinding or welding this material): Yes / No
- d. Beryllium: Yes / No
- e. Aluminum: Yes / No
- f. Coal (for example, mining): Yes / No
- g. Iron: Yes / No
- h. Tin: Yes / No
- i. Dusty environments: Yes / No
- j. Any other hazardous exposures: Yes / No

If "yes," describe these exposures: _____

4. List any second jobs or side businesses you have: _____

5. List your previous occupations: _____

6. List your current and previous hobbies: _____

7. Have you been in the military services? Yes / No

If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/ No

8. Have you ever worked on a HAZMAT team? Yes / No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes / No

If "yes," name the medications if you know them: _____

10. Will you be wearing protective clothing and/or equipment: Yes / No

If "yes," describe this protective clothing and/or equipment: _____

11. Will you be working under hot conditions (temperature exceeding 77 deg. F): Y / N

12. Will you be working under humid conditions: Yes / No

13. Describe the work you'll be doing: _____

14. Describe any special responsibilities you'll have that may affect the safety and well being of others (example, rescue, security): _____

15. If you have any health issues not addressed in this questionnaire that you feel may affect your performance of the one-mile walk and you believe it would be beneficial to speak with Dr. Prychodko, please check here

CLINICAL FINDINGS

BLOOD PRESSURE _____

PULSE _____

HEIGHT _____

WEIGHT _____

SPIROMETRY RESULTS ATTACHED

Date

Clinical Readings taken by (printed name *and* signature)