

# Firefighter Health and Medical Services

## **New Hire Information**

To prepare for your Health Assessment and Physical, we ask that you:

- Bring your completed medical history forms.
- Do not eat or drink for 8 hours prior to having your blood drawn. You may take your medicine, drink water, or black decaf coffee.
- Avoid tobacco in any form and caffeine for at least 3 hours.
- Wear clothing to permit freedom of movement, preferably shorts (and underwear), and walking or running shoes. You will be expected to perform sit-ups, push-ups, and ride a bicycle.
- Be prepared to give a urine sample.
- Bring your glasses.
- Avoid loud noises for 14 hours before the test. (You may need to wear earplugs to cut grass, etc.)
- Please arrive promptly at your scheduled time.
- Please call 864-560-9663 to cancel or reschedule your appointment.

**Your physical is scheduled for:**\_\_\_\_\_

Corporate Health - Spartanburg  
2660 Reidville Road, Unit  
Spartanburg, SC 29301  
P: 864-560-9696  
F: 864-560-9636

Corporate Health - Pelham  
150 D Street,  
Greer, SC 29651  
P: 864-879-1948  
F: 864-801-4398

**PHYSICIAN'S MEDICAL RECOMMENDATION REPORT FOR FIRE CHIEF OR EMPLOYER**

ASSOCIATE NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ JOB TITLE: \_\_\_\_\_

EMPLOYER / FIRE DEPARTMENT: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

***Based on current state, local and all applicable OSHA standards, work suitability determination for performing firefighter duties to include structural firefighting is as follows:***

\_\_\_\_\_ RECOMMENDED, NO LIMITATIONS

\_\_\_\_\_ RECOMMENDED WITH LIMITS

\_\_\_\_\_ NOT RECOMMENDED FOR INTERIOR FIRE FIGHTING

\_\_\_\_\_ MEDICAL CLEARANCE FOR USE OF RESPIRATOR

\_\_\_\_\_ NOT CLEARED FOR RESPIRATOR USE MEDICALLY

\_\_\_\_\_ HOLD FOR FURTHER EVALUATION

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Next Steps: \_\_\_\_\_ Retest  
\_\_\_\_\_ Medical Records  
\_\_\_\_\_ Referral to specialist

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

☐ 2660 Reidville Road, Unit 1  
Spartanburg, SC 29301  
Phone: 864-560-9651

☐ 150 D Street  
Greer, SC 29651  
Phone: 864-849-9180

**PHYSICIAN'S MEDICAL RECOMMENDATION REPORT FOR FIREFIGHTER**

ASSOCIATE NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ JOB TITLE: \_\_\_\_\_

EMPLOYER / FIRE DEPARTMENT: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

Physical Type: \_\_\_\_\_ (Full or Partial)

***Based on current state, local and all applicable OSHA standards, as well as, NFPA 1582 guidelines,  
work suitability determination for performing firefighter duties to include structural firefighting is as follows:***

\_\_\_\_\_ RECOMMENDED, NO LIMITATIONS

\_\_\_\_\_ RECOMMENDED WITH LIMITS

\_\_\_\_\_ NOT RECOMMENDED FOR INTERIOR FIRE FIGHTING

\_\_\_\_\_ MEDICAL CLEARANCE FOR USE OF RESPIRATOR

\_\_\_\_\_ NOT CLEARED FOR RESPIRATOR USE MEDICALLY

\_\_\_\_\_ HOLD FOR FURTHER EVALUATION

\_\_\_\_\_ OVERWEIGHT: OBESITY INDEX IS: \_\_\_\_\_ kg/m<sup>2</sup> (Ideal index is <25).  
*Suggest losing weight.*

\_\_\_\_\_ OBESE: OBESITY INDEX IS: \_\_\_\_\_ kg/m<sup>2</sup>  
*Stongly suggest medically supervised weight loss program.*

\_\_\_\_\_ SUGGEST FOLLOW UP FOR: \_\_\_\_\_  
*Follow up with your personal physician is recommended for the above listed condition.*

_____ PFT	<input type="checkbox"/>	Normal	<input type="checkbox"/>	Abnormal
_____ Hearing test	<input type="checkbox"/>	Normal	<input type="checkbox"/>	Abnormal
_____ Lab work	<input type="checkbox"/>	Normal	<input type="checkbox"/>	Abnormal
_____ EKG	<input type="checkbox"/>	Normal	<input type="checkbox"/>	Abnormal
_____ Fitness level	<input type="checkbox"/>	Pass	<input type="checkbox"/>	Fail

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Corporate Health Medical History Questionnaire

☐ 2660 Reidville Road, Unit 1  
Spartanburg, SC 29301  
Phone: 864-560-9651  
Fax: 864-560-9636

☐ 150 D Street  
Greer, SC 29651  
Phone: 864-849-9180  
Fax: 864-801-4398

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Company Name: \_\_\_\_\_

SSN: \_\_\_\_\_ Sex: \_\_\_\_\_ Birth Date: \_\_\_\_\_

### Section A - Have You Ever...

	Yes/No	If Yes, please explain...
had an operation		
received advice to have an operation		
been a patient in a psychiatric unit		
had a serious injury		
been refused employment for health reasons		
had a positive drug test result		
had or do you have an opiate or substance abuse addiction		
given up a job because of health reasons		
had to be hospitalized		
had a worker's compensation injury		
had a worker's compensation impairment rating		
received a VA disability rating		
received any long-term financial disability benefits		
been rejected or discharged from military service for health reasons		
been refused life insurance		
become ill because of your work		
had a driver's license revoked or denied for health reasons		
had or now have an illness which could affect your work		

### Section B - Regarding Your Health

	Yes/No		Yes/No
Have you ever injured your back		Have you ever had a head injury	
Have you ever worn a back brace		Do you need glasses to read	
Have you ever worn a knee brace		Do you need glasses for distance	
Do you ever wear a truss		Do you wear contact lenses	
Have you had (or do you have) a hernia or rupture		Do you ever use a hearing aid	
Have you ever had an illness treated with x-ray (cancer, etc)		Do you take medicine regularly (please list in Section E)	
Have you ever worked with radioactive material		Have you used "street" drugs (cocaine, speed, crack, heroin, marijuana, etc.)	
Have you ever worked in a dusty trade		Do you drink alcoholic beverages	

# Corporate Health Medical History Questionnaire

Patient Name: \_\_\_\_\_

SSN: \_\_\_\_\_

Section C - Any History Of		Yes/No			Yes/No
Allergies or reactions to drugs or chemicals			Joint pains or arthritis		
Asthma			Nervous breakdown/nerve trouble		
Blood in urine			Paralysis		
Cancer			Rheumatic fever		
Cough			Shortness of breath		
Diabetes			Skin rashes or eczema		
Epilepsy, fits, or convulsions			Stomach ulcer		
Fainting spells or dizziness			Swelling of legs or ankles		
Hay fever			Thyroid		
Headaches (frequent)			Tuberculosis		
Heart trouble			Urination difficulties		
High Blood Pressure			Varicose veins		
Jaundice or Hepatitis			Venereal disease		
Smoking			Other		
Section D - Immunizations		Yes/No		Yes/No	Yes/No
Are you up to date on: Tetanus (Lockjaw) - Date _____ Polio - Date _____ Hepatitis B - Date _____					
Section E - Medications					
Please list any medications you are currently taking _____					
Section F - Women Only					
Do you have any female or menstrual troubles _____			Are you pregnant _____ Yes/No		
Date of last period _____					
Section G - Prior Exposure					
Do you wear or use any of the following protective equipment?					
	Yes/No		Yes/No		Yes/No
Hearing protection		Face shield or eye goggles			
Dust mask		Safety shoes			
Respirator		Exhaust hood/containment device			
Lab coat or protective clothing		Shoe covers/hair cover			
Gloves		Hard hat			
Safety glasses					
Have you ever worked with or had significant exposure to the following hazards?					
	Yes/No		Yes/No		Yes/No
Vapors/gases		Extreme heat or cold			
Dusts (worked in dusty trade)		Vibration			
Metals		Radiation			
Biologic/infectious agents		Emotional stress			
Laboratory animals		Hazardous waste			
Loud Noise					
The above statements are true to the best of my knowledge. I understand that any misstatement is grounds for release or failure to complete hiring process.					
Signature of Job Applicant: _____					

Date: \_\_\_\_\_ Signature of Provider Reviewing Form \_\_\_\_\_

Patient Name: \_\_\_\_\_

SSN: \_\_\_\_\_

### PHYSICAL EXAMINATION

HEIGHT _____	WEIGHT _____	BMI _____	GLUCOSE
			<input type="checkbox"/> Fasting _____
BLOOD PRESSURE _____	PULSE _____		<input type="checkbox"/> Non-fasting _____
HEARING	VISION <input type="checkbox"/> WITHOUT GLASSES	<input type="checkbox"/> WITH GLASSES/CONTACTS	COLOR VISION _____
R _____	Far R _____ L _____	Both _____	PERIPHERAL VISION _____
L _____	Near R _____ L _____	Both _____	DEPTH PERCEPTION _____

CHECK ( ✓ ) IF NORMAL MARK ( O ) IF DEVIATION FROM NORMAL, GIVE DETAILS BELOW: Mark (N/E ) If not examined.

Skin scars <input type="checkbox"/>	Glands <input type="checkbox"/>	Lungs <input type="checkbox"/>	Extremities <input type="checkbox"/>
Head - Neck <input type="checkbox"/>	Thyroid <input type="checkbox"/>	Heart <input type="checkbox"/>	Neurological <input type="checkbox"/>
Nose - Sinuses <input type="checkbox"/>	Eyes <input type="checkbox"/>	Vessels <input type="checkbox"/>	Genito-Urinary <input type="checkbox"/>
Teeth - Gums <input type="checkbox"/>	Ears <input type="checkbox"/>	Abdomen <input type="checkbox"/>	Hernia <input type="checkbox"/>
Mouth - Throat <input type="checkbox"/>	Chest <input type="checkbox"/>	Joints <input type="checkbox"/>	Varicosities <input type="checkbox"/>
<u>SPINE</u>	<u>SPECIAL EXAMINATIONS</u>		
Motion <input type="checkbox"/>	Fundi <input type="checkbox"/>	Pelvis <input type="checkbox"/>	
Palpation <input type="checkbox"/>	Intraocular Tension <input type="checkbox"/>	Breasts <input type="checkbox"/>	
Deformities <input type="checkbox"/>	Rectum <input type="checkbox"/>	Other <input type="checkbox"/>	

DETAILS OF ABNORMAL FINDINGS:

PSYCHOLOGICAL STATUS: Normal \_\_\_\_\_ Abnormal: \_\_\_\_\_

Comment: \_\_\_\_\_

### LABORATORY FINDINGS:

URINALYSIS:	PRO _____	KET _____	SPECIAL PROCEDURES
LEU _____	pH _____	BIL _____	Chest x-ray _____
NIT _____	BLO _____	GLU _____	Other _____
URO _____	SG _____		Other _____

### SUMMARY OF ABNORMAL HISTORY AND PHYSICAL EXAM

### WORK SUITABILITY DETERMINATION:

- ☐ RECOMMENDED, NO LIMITATIONS
- ☐ RECOMMENDED, WITH LIMITATIONS \_\_\_\_\_
- ☐ NOT RECOMMENDED

THIS INDIVIDUAL HAS BEEN ADVISED OF THE FINDINGS OF THIS EXAMINATION.

☐ YES      Been advised to consult personal physician regarding \_\_\_\_\_

☐ NO

DATE \_\_\_\_\_ SIGNATURE OF EXAMINING PHYSICIAN \_\_\_\_\_

## Corporate Health

## OSHA Respirator Medical Evaluation Questionnaire

**Part A. Section 1. (Mandatory)** The following must be provided by every employee who uses any type of respirator.

Company: \_\_\_\_\_ Today's date: \_\_\_\_\_

1. Name: \_\_\_\_\_ 2. Date of Birth: \_\_\_\_\_ 3. Your age: \_\_\_\_\_ 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 the health care professional who reviews this questionnaire (include the Area Code): \_\_\_\_\_ 9. The best time to phone you at this number: \_\_\_\_\_

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

11. 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-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

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

If "yes," what type(s): \_\_\_\_\_

**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. 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: 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 problem 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 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: Yes/No

h. Coughing 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: Yes/No
  - e. Heartburn or indigestion that is not related to eating: Yes/No
  - d. 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: Yes/No

**If you've never used a respirator, check the following space and go to question 9.**

8. If you've used a respirator, have you *ever had* any of the following problems

- 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 problem that interferes with your use of a respirator: Yes/No

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

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

10. Have you *ever lost* vision in either eye (temporarily or permanently): Yes/No
11. Do you *currently* have any of the following vision problems?
- a. Wear contact lenses: Yes/No
  - b. Wear glasses: Yes/No
  - c. Color blind: Yes/No
  - d. Any other eye or vision problem: Yes/No
12. Have you *ever had* an injury to your ears, including a broken ear drum: Yes/No
13. Do you *currently* have any of the following hearing problems?
- a. Difficulty hearing: Yes/No
  - b. Wear a hearing aid: Yes/No
  - c. Any other hearing or ear problem: Yes/No
14. Have you *ever had* a back injury: Yes/No
15. Do you *currently* have any of the following musculoskeletal problems?
- 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: Yes/No

Any additional comments you would like to make: \_\_\_\_\_

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To the best of my knowledge, the information I have provided is true and accurate.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Part B

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Company Name: \_\_\_\_\_

Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional 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

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: 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 using any of the following items with your respirator(s)?

- a. HEPA Filters: Yes/No
- b. Canisters (for example, gas masks): Yes/No
- c. Cartridges: Yes/No

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:

- a. Escape only (no rescue): Yes/No
- b. Emergency rescue only: Yes/No
- c. Less than 5 hours *per week*: Yes/No
- d. Less than 2 hours *per day*: Yes/No
- e. 2 to 4 hours per day: Yes/No
- f. Over 4 hours per day: Yes/No

12. During the period you are using the respirator(s), is your work effort:

- a. *Light* (less than 200 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs. \_\_\_\_\_ mins.

Examples of a light work effort are *sitting* while writing, typing, drafting, or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines.

b. *Moderate* (200 to 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs. \_\_\_\_\_ mins.

Examples of moderate work effort are *sitting* while nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; *walking* on a level surface about 2 mph or down a 5-degree grade about 3 mph; or *pushing* a wheelbarrow with a heavy load (about 100 lbs.) on a level surface. c. *Heavy* (above 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs. \_\_\_\_\_ mins.

Examples of heavy work are *lifting* a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; *shoveling*; *standing* while bricklaying or chipping castings; *walking* up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/No

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

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes/No

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

16. Describe the work you'll be doing while you're using your respirator(s): \_\_\_\_\_

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases): \_\_\_\_\_

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

Name of the second toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

Name of the third toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

The name of any other toxic substances that you'll be exposed to while using your respirator: \_\_\_\_\_

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security): \_\_\_\_\_

To the best of my knowledge, the information I have provided is true and accurate.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## AUDIO HISTORY

Company \_\_\_\_\_ Date \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Last Name \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_ Shift \_\_\_\_\_

First Name \_\_\_\_\_ MI \_\_\_\_\_

### Medical History: Check Yes or No

	Yes	No		Yes	No
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>	Traumatic head injury	<input type="checkbox"/>	<input type="checkbox"/>
Ear drainage	<input type="checkbox"/>	<input type="checkbox"/>	Wear hearing aid	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/imbalance	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss (comes/goes)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Wax/object in ear canal	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Noise exposure before test	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss in family	<input type="checkbox"/>	<input type="checkbox"/>
Wear hearing protection	<input type="checkbox"/>	<input type="checkbox"/>	Head cold today	<input type="checkbox"/>	<input type="checkbox"/>
Recently prescribed drugs	<input type="checkbox"/>	<input type="checkbox"/>	Military service	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Noisy hobbies	<input type="checkbox"/>	<input type="checkbox"/>
Seen provider for ear problems	<input type="checkbox"/>	<input type="checkbox"/>	Loud music/headphones	<input type="checkbox"/>	<input type="checkbox"/>
Ear, head or neck surgery	<input type="checkbox"/>	<input type="checkbox"/>	Previous job with loud music	<input type="checkbox"/>	<input type="checkbox"/>
Trouble with hearing loss	<input type="checkbox"/>	<input type="checkbox"/>			

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**

### Otoscopic Exam (If Indicated)

	Left Ear	Right Ear
Clear	CL	CL
Infected or inflamed	IN	IN
Not performed	NP	NP
Partial Occlude - Cerumen	PC	PC
Partial Occlude - Foreign Body	PF	PF
Total Occlude - Cerumen	TC	TC
Total Occlude - Foreign Body	TF	TF

**Ear Canal Size**    ☐ Small    ☐ Medium    ☐ Large

\_\_\_\_\_  
**Examiner Signature**

\_\_\_\_\_  
**Date**



**GENERAL CONSENT TO TREAT/  
PATIENT AUTHORIZATION/ACKNOWLEDGEMENT OF BENEFITS RELEASE**

The following are the conditions for services provided by the Medical Group of the Carolinas which is affiliated with Spartanburg Regional Health Services District, Inc. (District) for the patient whose name appears at the bottom of this page.

**CONSENT FOR MEDICAL TREATMENT**

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Medical Group of the Carolinas and its associated hospitals, physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

**AUTHORIZATION FOR RELEASE OF INFORMATION**

The hospital, practice and attending physician are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

**UNDER ASSIGNMENT OF INSURANCE BENEFITS**

I/we hereby grant permission and consent to the District, our assignees, and third party collection agents: (1) to contact me by telephone at any telephone number associated with me, including wireless numbers: (2) to leave answering machine and voicemail messages for me, and include in any such messages information required by law (including debt collection laws) and/or regarding amounts owed by me: (3) to send me text messages or emails using any email addresses I provide: (4) to use pre-recorded/artificial voice messages and/or an automatic dialing device (an "auto dialer") in connection with any communications made to me or related to my account.

**ASSIGNMENT OF INSURANCE BENEFITS**

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and the District. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand the District can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected following the SC Setoff Debt Collection Act, I/we shall pay all collections fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

**WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION FORM**

I/we understand that South Carolina and North Carolina Worker's Compensation law provides that written information which pertains directly to a workers' compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Workers' Compensation Commission pursuant to the SC Code Ann § 42-15-95 and NC ST § 97-27. **I authorize Spartanburg Regional Healthcare System (SRHS) to provide copies of my medical records or to speak to duly authorized representatives of any of the above regarding my medical records, medical treatment, or condition.**

**PHOTO/VIDEO/TELEVISION**

I/we consent to photographs, televising and/or videotaping for identification, diagnosis and/or treatment purposes. I/we consent to video monitoring in patient care areas for clinical care and safety reasons.

**INDEPENDENT STATUS OF PHYSICIANS**

I/we understand and agree that some of the practitioners furnishing services to me/the patient, such as radiologists, pathologists and anesthesiologists may be independent contractors and not employees or agents of the Hospital. These independent contracted practitioners, not the Hospital, are responsible for their own acts or omissions. These independent contracted practitioners who render professional services to me/the patient may bill and collect separately from the Hospital. Furthermore, I/we understand that each healthcare provider may be individually contracted with an HMO or PPO. The contracts could be different from the contracts the Hospital holds. I/we understand that I/we need to find out if each healthcare provider is a member of my/the patient's insurance provider network.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I/we have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. The Notice of Privacy Practices may be accessed at [www.srhs.com](http://www.srhs.com).

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date and Time

\_\_\_\_\_  
Signature of Patient/(Relationship to Patient  
Parent, Guardian or Legally Authorized Representatives

\_\_\_\_\_  
Hospital Witness

\_\_\_\_\_  
Signature of Guarantor (Relationship to Patient)

# PAR-Q & YOU

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. <b>Has your doctor ever said that you have a heart condition <u>and</u> that you should only do physical activity recommended by a doctor?</b>
<input type="checkbox"/>	<input type="checkbox"/>	2. <b>Do you feel pain in your chest when you do physical activity?</b>
<input type="checkbox"/>	<input type="checkbox"/>	3. <b>In the past month, have you had chest pain when you were not doing physical activity?</b>
<input type="checkbox"/>	<input type="checkbox"/>	4. <b>Do you lose your balance because of dizziness or do you ever lose consciousness?</b>
<input type="checkbox"/>	<input type="checkbox"/>	5. <b>Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?</b>
<input type="checkbox"/>	<input type="checkbox"/>	6. <b>Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?</b>
<input type="checkbox"/>	<input type="checkbox"/>	7. <b>Do you know of <u>any other reason</u> why you should not do physical activity?</b>

If  
you  
answered

## YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

## NO to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active — begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal — this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

### DELAY BECOMING MUCH MORE ACTIVE:

- if you are not feeling well because of a temporary illness such as a cold or a fever — wait until you feel better; or
- if you are or may be pregnant — talk to your doctor before you start becoming more active.

**PLEASE NOTE:** If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

**Informed Use of the PAR-Q:** The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

**No changes permitted. You are encouraged to photocopy the PAR-Q but only if you use the entire form.**

NOTE: If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

SIGNATURE OF PARENT \_\_\_\_\_  
or GUARDIAN (for participants under the age of majority)

WITNESS \_\_\_\_\_

**Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.**

**SUBMAXIMAL BICYCLE TEST**

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

SSN: \_\_\_\_\_ Position: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ WT: \_\_\_\_\_ HT: \_\_\_\_\_ Sex: ☐ M ☐ F

Participant has completed:

\_\_\_\_\_ Fitness Readiness Screening \_\_\_\_\_ Informed Consent \_\_\_\_\_ PAR questionnaire

**PRE-TEST INFO**

220- \_\_\_\_\_ = \_\_\_\_\_ X 0.85= \_\_\_\_\_ (HR Upper Limit) Resting B/P: \_\_\_\_\_  
(age) max HR X 0.75= \_\_\_\_\_ (HR Lower Limit) Resting Pulse: \_\_\_\_\_

**PHYSICAL FINDINGS**

- ☐ Alert  
☐ Activity Level: ☐ Inactive ☐ Active ☐ Very Active  
☐ Smoke ☐ Dip ☐ Chew

Have you recently experienced any illness or symptoms that would make physical activity challenging?

☐ Yes ☐ No If yes, provider should be made aware before beginning the bicycle test.**Warm up 2-4 min. b/t 50-60 rpm**

STAGE	WORKLOAD	B/P	HR	RPE
1	50 watts	_____	_____ (5min)	_____
2	_____	_____	_____ (9min)	_____
3	_____	_____	_____ (13min)	_____
4	_____	_____	_____ (17min)	_____
5	_____	_____	_____ (22min)	_____

HOLD	B/P	HR	RPE
85% max	_____	_____ (2 min)	_____

RECOVERY:	B/P	HR
1ST minute	_____	_____
2ND minute	_____	_____
3RD minute	_____	_____

**HEMODYNAMICS DURING TEST (optional)**

- ☐ Tolerated test well  
☐ Asymptomatic  
☐ Symptomatic  
☐ chest pain ☐ shortness of breath ☐ nausea ☐ hypotension ☐ hypertension ☐ other  
Other comments \_\_\_\_\_

**POST TEST INFO**

Physical findings:

- ☐ Returns to baseline quickly  
☐ Recovers well  
☐ Other: \_\_\_\_\_

Exercise BP Max: \_\_\_\_\_

Exercise HR Max: \_\_\_\_\_

Max Workload: \_\_\_\_\_

\_\_\_\_\_  
Evaluator Signature\_\_\_\_\_  
Date

## Exercise Test Questionnaire and Informed Consent

Name: \_\_\_\_\_ Soc.Sec #: \_\_\_\_\_

**Please circle the correct answer.**

1. Has your physician ever told you:
  - That you have heart trouble?    yes    no
  - That your blood pressure is too high?    yes    no
  - That you have a bone or joint problem that would be aggravated by exercise?    yes    no
2. Do you ever feel faint or dizzy?    yes    no
3. Do you ever have chest pains?    yes    no
4. Is there a good reason why you should not follow an exercise program?    yes    no

You will perform a sub-maximal exercise test on a bicycle. The exercise intensity will begin at a low level and be advanced in stages depending on your fitness level. The test may be stopped at any time due to signs of fatigue, changes in heart rate or blood pressure. You may stop the test at any time you wish because of feelings of fatigue or discomfort.

You may experience certain changes during this test. They may include abnormal blood pressure, fainting, irregular, fast or slow heartbeat, and in rare instances, heart attack, stroke and death. Every effort will be made to minimize these risks by evaluation of preliminary information and by observation during the test. Emergency equipment and trained personnel are available to deal with unusual situations that may arise.

Information about your health status or previous experiences of unusual feelings with physical effort may affect the safety and value of the exercise test. It is very important that you report your feelings during the test to the staff. You are responsible for fully disclosing such information to the staff.

The results obtained from this test may assist in the diagnosis of an illness.

Your permission to perform this exercise test is voluntary. You are free to stop the test at any point. Please ask the staff any questions that you may have about the test or its results.

**I have read this form, and understand the test procedures, the risks and benefits, and discomforts that may occur. I have been given the opportunity to ask questions. I consent to participate in this test.**

---

**Participant Signature**

---

**Date**

---

**Witness Signature**

---

**Date**

*Thank you for choosing Spartanburg Regional for your organization's healthcare needs*

**PATIENT INFORMATION**

**Please print or write legibly**

Date: \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M F \_\_\_\_\_ Marital Status: S M LS D W

Social Security#: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Email address: \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Preferred Phone: home cell work (circle one)

Street Address (if different from mailing) \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Language \_\_\_\_\_

**Race:** [ ] White/Caucasian [ ] Black/African American [ ] Native Hawaiian [ ] AM Indian/Alaska Nat  
[ ] Asian/E Indian [ ] Unavailable/Unknown

**Ethnicity:** [ ] Hispanic/Latino [ ] Not Hispanic/Latino [ ] Declined