the Chickasaw Nation
Department of Health / Support Division
Employee Health
1921 Stonecipher Boulevard / Ada, OK 74820 / (580) 436-3980

Bill Anoatubby
Governor

Limited Health History/Latex Screening Questionnaire

Employee name: _____ Date: _____

Department/work area: _____

Occupational history:

1. Does your occupation involve exposure to natural rubber latex? ☐ Yes ☐ No

Medical history:

1. Do you have an allergy to any latex products? ☐ Yes ☐ No
2. Have you experienced local swelling, itching or?
   Dermatitis (skin inflammation) associated to contact with latex? ☐ Yes ☐ No
3. Do you have a tendency to have multiple allergic conditions? ☐ Yes ☐ No
4. Do you have any congenital abnormalities? ☐ Yes ☐ No
5. Do you have any food or drug allergies? ☐ Yes ☐ No
   If yes, what foods/drugs: _____
6. Do you have history of: (check all that apply)?

Skin inflammation(dermatitis	☐ Yes	☐ No	Hives (Uriticaria)	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hay fever	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No	Coughing	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No	Sneezing	☐ Yes	☐ No

Itching or runny nose (rhinitis) ☐ Yes ☐ No

Itching or runny eyes (conjunctivitis) ☐ Yes ☐ No

Surgical history:

1. Have you ever had surgery? ☐ Yes ☐ No
   If yes, list (include dental surgery)

_____

_____

_____

Other Comments: _____

Employee Signature/date: _____

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Tuberculosis Screening Questionnaire

Date: _____

Employee name: _____

Department/work area: _____

Birth date: _____

Date of positive TB test: _____ ☐ N/A

Date of disease: _____ ☐ N/A

Treated with Tuberculosis medication? ☐ Yes ☐ No ☐ N/A

Duration of treatment: _____

Name(s) of medication: _____

Have you been exposed to an isolated case of TB this year? ☐ Yes ☐ No

Do you have any of the following:

Chronic cough	☐ Yes	☐ No
With sputum	☐ Yes	☐ No
Color of sputum	_____	
Persistent night sweats	☐ Yes	☐ No
Involuntary weight loss	☐ Yes	☐ No
Chronic fatigue	☐ Yes	☐ No
Any serious illness	☐ Yes	☐ No

If you answered yes to any of the above, please explain:

_____
_____
_____
_____
_____
_____

Employee signature: _____

Date/time: _____

+Name (Person #1): Last Name _____ First Name _____ M.I. _____

Address Street _____ Apt. # _____ City _____ Zip Code _____

Phone Main # _____ Other # _____ County _____

Official Use Only

Distribution Site:

Date:

TIME IN: **TIME OUT:**

PLEASE PRINT	Person #1	Person #2	Person #3	Person #4	Person #5
LAST NAME: **FIRST NAME:**	**Name Above (Person picking up)**				
BIRTHDATE:	(MM / DD / YYYY)	(MM / DD / YYYY)	(MM / DD / YYYY)	(MM / DD / YYYY)	(MM / DD / YYYY)
SEX: **WEIGHT,** only if LESS than 76 pounds**:**	☐ Male ☐ Female #_____ pounds	☐ Male ☐ Female #_____ pounds	☐ Male ☐ Female #_____ pounds	☐ Male ☐ Female #_____ pounds	☐ Male ☐ Female #_____ pounds
Pregnant/Breastfeeding	☐ Yes ☐ No/NA	☐ Yes ☐ No/NA	☐ Yes ☐ No/NA	☐ Yes ☐ No/NA	☐ Yes ☐ No/NA
Allergic to Tetracyclines?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Allergic to Quinolones?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Allergic to Penicillins?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
No Allergies or Unknown	☐ None ☐ Unknown	☐ None ☐ Unknown	☐ None ☐ Unknown	☐ None ☐ Unknown	☐ None ☐ Unknown

Names of Drugs	Tetracycline Drugs		Quinolone Drugs				Penicillin Drugs			
	Doxycycline	Sumycin	Avelox	Floxin	Levafloxacin	Tequin	Amoxicillin	Augmentin	Penicillin	V-Cillin
	Minocin	Tetracycline	Cipro	Gaitfloxacin	Moxifloxacin		Amoxil	Pen VK	Principen	
	Minocycline	Vibramycin	Ciprofloxacin	Levaquin	Ofloxacin		Ampicillin	Pen G	Trimox	

I have been given disease & medicine fact sheets and medicine for people listed on this form. I agree to give them the information and medicine. I understand this medicine is meant to keep us from getting sick. If I or any of them gets sick, or is already sick, we should see a doctor. I have received and understand my HIPAA rights.

Signature (Person #1): _____

STOP! Do NOT fill out the information below.

Dispenser Initials		Person #1	Person #2	Person #3	Person #4	Person #5
	Medication	❒ Doxycycline ❒ Cipro ❒ _____	❒ Doxycycline ❒ Cipro ❒ _____	❒ Doxycycline ❒ Cipro ❒ _____	❒ Doxycycline ❒ Cipro ❒ _____	❒ Doxycycline ❒ Cipro ❒ _____
	Dosage	❒ 100mg BID ❒ 500mg BID ❒ _____	❒ 100mg BID ❒ 500mg BID ❒ _____	❒ 100mg BID ❒ 500mg BID ❒ _____	❒ 100mg BID ❒ 500mg BID ❒ _____	❒ 100mg BID ❒ 500mg BID ❒ _____
	Labeling	Rx#_____ Lot#_____ NDC#_____ Expiration _____	Rx#_____ Lot#_____ NDC#_____ Expiration _____	Rx#_____ Lot#_____ NDC#_____ Expiration _____	Rx#_____ Lot#_____ NDC#_____ Expiration _____	Rx#_____ Lot#_____ NDC#_____ Expiration _____

Dispensing Nurse Signature _____

OSHA Respirator Medical Evaluation Questionnaire (Mandatory) Appendix C to Sec. 1910.134:

Part A. Section 1. (Mandatory) Any individual who has been selected to use any type of respirator (please print) must provide the following information.

Today's date _____ Date of Birth: _____

Name _____ SSN: _____

Job Title _____ Sex: Male ◯ Female ◯

Home Phone: _____ Height: ____ (ft) ____ (in) Weight ____ (lbs)

Work Phone: _____

Can you read English? . . . . . Yes ◯ NO ◯

Has your employer told you how to contact the health care professional who will review this? Yes ☐ NO ☐

Check the type of respirator you will use (you can check more than one category):

a 95 N, R, or P disposable respirator (filter-mask, non-cartridge type only).

b ___ Other type

☐ Powered-air purifier

☐ Half-face

☐ Supplied-air

☐ Full-facepiece type (includes gas mask)

☐ Self-contained breathing apparatus

Have you worn a respirator in the past?: . . . . . Yes ☐ NO ☐

If ``yes,'' what type(s): _____

Physical exertion while wearing a respirator ☐ Mild ☐ Moderate ☐ Strenuous

Maximum time you wear a respirator in a single day?: ____ hours

Do you exercise? . . . . . Yes ☐ NO ☐

If ``yes,' describe how often and what exercise activities are: _____

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 select ``yes'' or ``no'').

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

If Yes, how many packs per day? ☐ 1/2 or less ☐ 1 ☐ 2 ☐ 2 or more

How many years have you smoked? ☐ 1-9 ☐ 10-19 ☐ 20-29 ☐ 30 or more

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

Seizures (fits) Yes ☐ NO ☐

Diabetes (sugar disease) Yes ☐ NO ☐

Allergic reactions that interfere with your breathing Yes ☐ NO ☐

Claustrophobia (fear of closed-in places) Yes ☐ NO ☐

Trouble smelling odors Yes ☐ NO ☐

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

Asbestosis Yes ☐ NO ☐

Asthma Yes ☐ NO ☐

Chronic bronchitis: Yes ☐ NO ☐

Emphysema: Yes ☐ NO ☐

Pneumonia Yes ☐ NO ☐

Tuberculosis Yes ☐ NO ☐

Silicosis Yes ☐ NO ☐

Pneumothorax (collapsed lung) Yes ☐ NO ☐

Lung cancer Yes ☐ NO ☐

Broken ribs: Yes ☐ NO ☐

Any chest injuries or surgeries: Yes ☐ NO ☐

Any other lung problem that you've been told about: Yes ☐ NO ☐

Name _____

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

Shortness of breath:	Yes ☐	NO ☐
Shortness of breath when walking fast on level ground or walking up a slight hill/incline	Yes ☐	NO ☐
Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes ☐	NO ☐
Have to stop for breath when walking at your own pace on level ground:	Yes ☐	NO ☐
Shortness of breath when washing or dressing yourself:	Yes ☐	NO ☐
Shortness of breath that interferes with your job:	Yes ☐	NO ☐
Coughing that produces phlegm (thick sputum):	Yes ☐	NO ☐
Coughing that wakes you early in the morning:	Yes ☐	NO ☐
Coughing that occurs mostly when you are lying down:	Yes ☐	NO ☐
Coughing up blood in the last month:	Yes ☐	NO ☐
Wheezing:	Yes ☐	NO ☐
Wheezing that interferes with your job:	Yes ☐	NO ☐
Chest pain when you breathe deeply:	Yes ☐	NO ☐
Any other symptoms that you think may be related to lung	Yes ☐	NO ☐

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

Heart attack	Yes ☐	NO ☐
Stroke:	Yes ☐	NO ☐
Angina:	Yes ☐	NO ☐
Heart Failure:	Yes ☐	NO ☐
Swelling in your legs or feet (not caused by walking):	Yes ☐	NO ☐
Heart arrhythmia (heart beating irregularly):	Yes ☐	NO ☐
High blood pressure:	Yes ☐	NO ☐
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?

Frequent pain or tightness in your chest :	Yes ☐	NO ☐
Pain or tightness in your chest during physical activity	Yes ☐	NO ☐
Pain or tightness in your chest that interferes with your job	Yes ☐	NO ☐
In the past two years, have you noticed your heart skipping or missing a beat :	Yes ☐	NO ☐
Heartburn or symptoms that is not related to eating	Yes ☐	NO ☐
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?

Breathing or lung problems:	Yes ☐	NO ☐
Heart trouble:	Yes ☐	NO ☐
Blood Pressure:	Yes ☐	NO ☐
Seizures(fits)::	Yes ☐	NO ☐

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)

Eye irritation:	Yes ☐	NO ☐
Skin allergies or rashes:	Yes ☐	NO ☐
Anxiety:	Yes ☐	NO ☐
General weakness or fatigue:	Yes ☐	NO ☐
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 ☐

Name _____

Employee Signature: _____ **Date:** _____

Parent/Legal Representative Signature: _____ **Date:** _____

**** Note: signing this document gives CNDH permission to perform a respiratory fit test on the above signed individual in accordance with the standards set forth in OSHA 29 CFR 1910.134 ****

Additional Notes: _____

_____

_____

_____

_____

_____

TO BE COMPLETED BY THE EXAMINER/REVIEWER:

This employee has been found to be physically able to use the following (check each [ ] that applies):

- ☐ Single use, filter mask (four attachment points)
- ☐ Half-faced cartridge-type, negative pressure
- ☐ Full-faced cartridge-type respirator, negative pressure
- ☐ Half-faced powered cartridge-type (PAPR)
- ☐ Full-faced powered cartridge-type (PAPR)
- ☐ Self-contained breathing apparatus (SCBA)
- ☐ Hood/helmet powered cartridge-type (PAPR)
- ☐ Half-faced/Full-faced/Hood/Helmet (NOT positive pressure)

Restrictions / Limitations (if any) when wearing a respirator:

_____

- ☐ ***This employee has been found to be physically NOT able to use a respirator***
- ☐ ***There is insufficient information to make a determination at this time***
- ☐ ***The mandatory questionnaire has been reviewed, and the employee has been found to be physically able to use a respirator.***
- ☐ ***The mandatory questionnaire has been reviewed but there is insufficient information to make a determination at this time.***

This respirator clearance expires **1** ◯ **2** ◯ **3** ◯ years from the date below. (*If not marked, clearance expires in 1 year*)

_____ _____ _____

Reviewer's Name (Print) **Reviewer's Signature** **Date:**