**CLALLAM COUNTY FIRE DISTRICT #5**

# MEDICAL QUESTIONNAIRE FOR SCBA USERS

NAME SOCIAL SECURITY NO.

ADDRESS CITY, STATE ZIP PHONE NUMBER

AGE HEIGHT WEIGHT

Have you ever worn an SCBA before? YES ☐ NO ☐

If YES, describe any apparent difficulties noted with SCBA use:

Have you had, or do you now have any of the following?

| YES | NO | |
|---|---|---|
| | | Lung Disease |
| | | Persistent Cough |
| | | Heart Trouble |
| | | Shortness of breath |
| | | History of Fainting or Seizure |
| | | High Blood Pressure |
| | | Diabetes |
| | | Fear of Tight or Enclosed Places |
| | | Sensation of Smothering |
| | | Heat Exhaustion or Heat Stroke |
| | | Ruptured Eardrum |
| | | Defective Vision |
| | | Defective Hearing |
| | | Contact Lenses or Glasses |
| | | Other conditions that might interfere with SCBA use or result in limited work ability |
| | | Are you taking any medications? |

Please explain all YES answers:

Comments:

Signature Date