NowCare-Suffolk Urgent Care Center • 3060 Godwin Blvd., Suffolk, VA 23434 • 757-935-5310

Employer Medical Examination
Isle of Wight Fire Rescue Personnel

Welcome to NowCare Health and Safety. Our goal is for you to have a pleasant experience, while at the same time providing you with the most complete and accurate information regarding your health. Please take a moment to review the contents of this packet. To help you prepare for your appointment, we've included a map to NowCare, components of the medical examination, and additional pertinent information.
We look forward to your visit with us!

Here are a few things we need from you in order to make your exam as thorough and as smooth as possible:

1. Schedule your appointment with NowCare
    a. Email NCSuffolk@bayviewphysicians.com or callis@bayviewphysicians.com

2. Please fill out the following forms prior to your appointment at NowCare
    a. Isle of Wight Authorization
    b. Medical History
    c. Respirator Questionnaire
    d. Employee Aural History

3. You will be required to fast from all food and beverages (water is permitted) at least 6 hours prior to your appointment. This is necessary to obtain the most accurate laboratory results.

If you have any questions or concerns, please contact Eileen or Brean. We are happy to discuss the process and answer any questions by phone or email. We look forward to working with you!

Clinical Coordinator: Brean Callis
Office: 757-935-5310
Cell: 757-235-5410
Email: callis@bayviewphysicians.com

OccHealth Assistant Eileen Anthony
Office: 757-935-5310
Email: anthony@bayviewphysicians.com

Sincerely,

NowCare Occupational Health Team

NowCare-Suffolk
3060 Godwin Blvd., Suffolk, VA 23434
Ph: 757-935-5310 Fx: 757-935-5311

Isle of Wight Authorization

(*Please Print and Complete All Fields)*

First Name	Middle Name	Last Name	Employer ID

Street Address	Apt #	Lot #

City	State	Zip Code

Phone #	Date of Birth	Sex	Marital Status
		☐ Male ☐ Female	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employer Information:

Department	Address/ Location	Work Phone

Consent for Treatment

Isle of Wight County has arranged this physical examination for me as part of a policy of routine health screening for fire fighters, police officers and emergency medical personnel.

I understand why this physical is being performed and at the direction of my employer, Isle of Wight County, I consent to this medical examination.

I have read the above authorization and fully understand the same.

Patient Name (Print)	Patient Signature	Date

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Medical History

Last Name	First Name	MI	Today's Date

DOB	Age	Sex	Marital Status
		☐M ☐F	☐Married ☐Single ☐Separated ☐Divorced ☐Widowed

Current Job:		Position applying for:	
Can you perform this job without any accommodations?	No	Yes	

Your Personal Health Information is confidential and is not disclosed to the company. Full disclosure of your health status is required. Thank you for your cooperation.

Classify your current state of health: Fair_____ Good_____ Excellent_____

Prescription Medications: List all

Allergies: List all

Have you ever smoked?	No	Yes	Do you smoke now?	No	Yes	
How many years have you or did you smoke?			How many packs a day?			

Family History: Has any blood relative ever been diagnosed with any of the following conditions? ☐Yes ☐ No
☐ Heart Disease / Heart Attack ☐ High Blood Pressure ☐ Stroke ☐ Diabetes ☐ Cancer
If yes, list family member and specific disease:

Sensory Problems:			
			Provider Comments:
Vision (Not corrected with lenses)	No	Yes	
Hearing	No	Yes	
Balance	No	Yes	
Sleep Disturbance (Apnea)	No	Yes	

Cardiovascular Disease:			
			Provider Comments:
Hypertension (High Blood Pressure)	No	Yes	
Heart Attack/ Angina / Stent/ Bypass	No	Yes	
Pulmonary Embolus / Blood Clots	No	Yes	
Do you take Blood Thinners?	No	Yes	
Heart Failure	No	Yes	
Irregular Heart Beat (A fib, SVT)	No	Yes	
Other Cardiovascular disease (Abnormal EKG, Stress Test, Murmur, etc….) List:_____	No	Yes	

Pulmonary Disease:			
			Provider Comments:
Chronic Obstructive Pulmonary Disease (COPD)	No	Yes	
Asthma	No	Yes	
Other Pulmonary Disease: List:_____	No	Yes	

Endocrine Disease:			
			Provider Comments:
Diabetes	No	Yes	
Are you on Insulin?	No	Yes	
Thyroid Disease	No	Yes	
Kidney Disease	No	Yes	
Other Endocrine Disease: List:_____			
Neurological Disease:			
			Provider Comments
Stroke or "TIA"	No	Yes	
Neurosurgery	No	Yes	
Epilepsy (History of seizures)	No	Yes	
Chronic Neurological Disease (Multiple Sclerosis, Parkinson's Disease, etc…) List:_____	No	Yes	
Syncope (Fainting)	No	Yes	
Traumatic Brain Injury (TBI)	No	Yes	
Other Neurological Disease: List:_____	No	Yes	
Mental Health:			
			Provider Comments:
Anxiety	No	Yes	
ADD / ADHD	No	Yes	
Other Mental Health Disorder: List:_____	No	Yes	

PHQ2-Evaluation

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Give answers as 0 to 3, using this scale:

0= Not at all	*1= Several days*	*2= More than half the days*	*3= Nearly everyday*

1. Little interest or pleasure in doing things?
   ☐ 0 ☐ 1 ☐ 2 ☐ 3
2. Feeling down, depressed, or hopeless?
   ☐ 0 ☐ 1 ☐ 2 ☐ 3

Clinic Instructions: Calculate score based on responses. Total Score: _____ Refer to PHQ9 with positive findings.

Musculoskeletal:			
			Provider Comments:
Neck / Back / Extremity Problems Body Part:_____	No	Yes	
Surgery	No	Yes	
Injury	No	Yes	
Pain	No	Yes	
Arthritis	No	Yes	
Other Musculoskeletal Disorders: List:_____	No	Yes	
Other:			
Dermatitis	No	Yes	
Stomach / Digestive / Liver Disease	No	Yes	
Blood Disorders	No	Yes	
Cancer Type:_____	No	Yes	

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate this examination.

Applicant Signature:_____ **Date**:_____

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Please complete this form using black ink. Please review form as needed, using a different color ink ex: blue/red.			
2nd Review Date	3rd Review Date	4th Review Date	5th Review Date

Employer: Answers to questions in Section 1 and to question 9 in Section 2 of Part A do not require a medical examination. "Yes" answers to any question in section 2 (1-8) requires a follow up medical examination.

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.

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. Todays Date	2. Your Name	3. Your Age (To nearest year)	4. Sex (Circle one)	5. Your Height	6. Your Weight
			M F	ft. ins.	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 is:

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. Disposable respirator (filter-mask, non cartridge type only)
- ☐ **N** (Not resistant)
- ☐ **R** (Resistant)
- ☐ **P** (Proof, oil)

b. Other types
- ☐ Half Face Piece ☐ Full Face Piece
- ☐ Powered Air Purifying ☐ Supplied Air
- ☐ SCBA (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. or as indicated.		
1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month?	Yes	No
If yes, how much do you smoke? **#Packs per day: # Packs per week: #Packs per month:**		
How long have you smoked? **Months: Years:**		
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? **If yes when?**		
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 c*urrently* 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 a 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? **If yes when?**		
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? **If yes when?**		
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 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
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): **If yes when?**		
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 that will review this questionnaire about your answers to this questionnaire?	Yes	No

Full Face piece or SCBA: 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)? **If yes when**	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 problems:	Yes	No
12. Have you *ever* had an injury to your ears, including a broken ear drum? **If yes when?**	Yes	No
13. Do you c*urrently* 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? **If yes when?**	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
Part B 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 you 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?		
If "Yes," name the chemicals if you know them and **when** you were exposed.		
3. Have you ever worked with any of the materials, or under any of the conditions listed below? **If yes when?**		
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 pervious occupations:		
6. List your current and previous hobbies:		
7. Have you been in the military services? **If yes when?**	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? **If yes when?**	Yes	No

9. Other than medication for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medication for any reason (including over the counter medication):	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 efforts:		
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 light work efforts 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 3mph; 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 2mph; 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 the protective clothing and/or equipment:		
14. Will you be working under hot conditions (temperature exceeding 77°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:		
17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) for example, confined space, life threatening gases etc.:		

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 toxic substance		

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

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HEALTH & SAFETY

Employee Aural History Form

Last Name	First Name	SS#	Today's Date

Military Service: Which Branch?	How many years?	
Where you exposed to gunfire of noise:	☐Yes ☐No	
Did you wear ear protection?	☐Yes ☐No	If yes: ☐Plugs ☐Muffs ☐Both

Employer:	**Exposed To Noise**	**Hearing Protection**
Present:	☐Yes ☐No	☐Plugs ☐Muffs ☐Both
Past:	☐Yes ☐No	☐Plugs ☐Muffs ☐Both

Hobbies:		
Check if you have ever had any of these hobbies. Check if you used hearing protection		
☐Race Cars or Motorcycles	☐Yes ☐No	☐Plugs ☐Muffs ☐Both
☐Loud Music	☐Yes ☐No	☐Plugs ☐Muffs ☐Both
☐Saws or Loud Equipment	☐Yes ☐No	☐Plugs ☐Muffs ☐Both
☐Use of Firearms	☐Yes ☐No	☐Plugs ☐Muffs ☐Both
☐Hunt /Target Shoot	☐Yes ☐No	☐Plugs ☐Muffs ☐Both
☐Other noisy hobbies:	☐Yes ☐No	☐Plugs ☐Muffs ☐Both

Medical History: Have you had or currently have any of the following?		
1.	Family history of hearing loss	☐Yes ☐No
2.	Measles	☐Yes ☐No
3.	Current cold or sinus problem	☐Yes ☐No
4.	Frequent ear aches	☐Yes ☐No
5.	Dizziness	☐Yes ☐No
6.	Ringing in the ears	☐Yes ☐No
7.	Temporary hearing loss	☐Yes ☐No
8.	Head injury requiring hospitalization	☐Yes ☐No
9.	Ever taken antibiotics for long periods	☐Yes ☐No
10.	Had ear surgery or seen by an ear doctor	☐Yes ☐No
11.	Do you wear a hearing aid:	☐Yes ☐No Which ear?
Comments for any positive answer:_____		
_____		
_____		

For Staff Use Only

History Update: Write today's date and check below if the patient has experienced any of the following since their last hearing test. If not, check no change.

Date	Earaches	Ear or head injury	Major surgery	Dizziness	Ringing In ears	New noisy hobbies	No Change