



**MATRAC**  
Healthcare Coalition

**Annual Medical Questionnaire**  
**CONFIDENTIAL**

To be completed and signed by the team member. Please print.

New     Annual Update  
 Change in status

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

		Y	N
1.	Do you currently smoke tobacco, or have you smoked tobacco in the last month?		
2.	Have you <b>ever had</b> any of the following conditions?	Seizures (fits)	
		Diabetes (sugar disease)	
		Allergic reactions that interfere with your breathing	
		Claustrophobia (fear of closed-in places)	
		Trouble smelling odors	
3.	Have you <b>ever had</b> any of the following pulmonary or lung problems?	Asbestosis	
		Asthma	
		Chronic bronchitis	
		Emphysema	
		Pneumonia	
		Tuberculosis	
		Silicosis	
		Pneumothorax (collapsed lung)	
		Lung cancer	
		Broken ribs	
		Any chest injuries or surgeries	
Any other lung problem that you've been told about			
4.	Do you <b>currently</b> have any of the following symptoms of pulmonary or lung illness?	Shortness of breath	
		Shortness of breath when walking fast on level ground or walking up a slight hill or incline	
		Shortness of breath when walking with other people at an ordinary pace on level ground	
		Have to stop for breath when walking at your own pace on level ground	
		Shortness of breath when washing or dressing yourself	
		Shortness of breath that interferes with your job	
		Coughing that produces phlegm (thick sputum) not associated with a cold	
		Coughing that wakes you early in the morning	
		Coughing that occurs mostly when you are lying down	
		Coughing up blood in the last month	
		Wheezing	
		Wheezing that interferes with your job	
		Chest pain when you breathe deeply	
		Any other symptoms that you think may be related to lung problems	
5.	Have you <b>ever had</b> any of the following cardiovascular or heart problems?	Heart attack	
		Stroke	
		Angina	
		Heart failure	
		Swelling in your legs or feet (not caused by walking)	
		Heart arrhythmia (heart beating irregularly)	
		High blood pressure	
		Any other heart problem that you've been told about:	
		Angina	
Heart failure			

		Y	N
6. Have you <b>ever had</b> any of the following cardiovascular or heart symptoms?	Frequent pain or tightness in your chest		
	Pain or tightness in your chest during physical activity		
	Pain or tightness in your chest that interferes with your job		
	In the past two years, have you noticed your heart skipping or missing a beat		
	Heartburn or indigestion that is not related to eating		
	Any other symptoms that you think may be related to heart or circulation problems		
	Frequent pain or tightness in your chest		
	Pain or tightness in your chest during physical activity		
7. Do you <b>currently</b> take medication for any of the following problems?	Breathing or lung problems		
	Heart trouble		
	Blood pressure		
	Seizures (fits)		
	Other (Explain)		
8. If you've used a respirator, have you <b>ever had</b> any of the following problems? (If you've never used a respirator, check the following space and go to question 9) <input type="checkbox"/>	Eye irritation		
	Skin allergies or rashes		
	Anxiety		
	General weakness or fatigue		
	Any other problem that interferes with your use of a respirator		
9. Would you like to talk to the health care professional who will review this questionnaire about your answers?			

Any ER visits, hospitalizations, surgeries, or ongoing therapy during the last 12 months?  Yes  No If yes, please explain and include dates: \_\_\_\_\_

MEDICATIONS	HOW OFTEN	REASON FOR TAKING
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies (food, medication, insect, dust, latex, etc): What happens? What do you do? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all medical equipment or assistive devices used (crutches, canes, nebulizer, CPAP, oxygen, braces, wheelchair, service animals, etc): \_\_\_\_\_  
 \_\_\_\_\_

I have reviewed the *Fitness for Duty Guidelines* and understand the physical requirements for being an SMAT/MRC responder and hereby state that I am able to fulfill those requirements. I understand that if my health status changes, I am responsible for updating this form immediately and submitting to MATRAC administration. I give permission for MATRAC's medical director to review my health information to ensure both my own safety and the safety of my team.

*My typed signature/date is verification that the information on this form is correct. Either typed or written is acceptable.*

Signature of team member: \_\_\_\_\_ Date: \_\_\_\_\_

Due to regulations for MATRAC's Respiratory Protection Program, it is necessary for this form to be updated annually.