HIALEAH FIRE DEPARTMENT

Please complete your patient packet and bring it with you to your Life Scan physical.
The Life Scan Firefighter Wellness Program is an integrated medical approach that combines a comprehensive, hands-on physical and the Health & Wellness Initiative with a model of early detection and prevention of the major diseases such as heart disease, stroke, cancer, diabetes, and aneurysms before they reach a catastrophic level. It provides you with a thorough assessment of your health as well as recommendations for achieving and maintaining long term health and managing medical risks.

Each physical exam has the added value benefit of ultrasound imaging assessments of the internal organs and cardiovascular system as well as cardio-pulmonary testing, extensive laboratory blood profiles, diet and nutritional analysis, a state-of-the-art fitness analysis, and a personalized wellness plan.

Life Scan’s sophisticated wellness program is proven to identify and analyze specific markers that are the foundation of virtually every disease, visualizes the health of the internal organs and heart, and evaluates the function of the vascular system. The 8-level fitness evaluation with our exercise physiologist will put you on the right track to an improved physical condition.

Early detection is the Key to Prevention

To your Health!

Patricia Johnson, Founder and CEO
Ruth Johnson, Vice President
Tammy Torres, Director
Anthony Capasso, M.D., Medical Director
LIFE SCAN
Wellness Center

PATIENT INFORMATION

Exam Date: 

Patient Name: ____________________________
  Last  First  Middle Initial

Patient Employee ID#: ____________________________

Birth Date: _______________  Age _______  Circle One:  Male  Female

Employer: ____________________________

Position or Title: ____________________________  Station or Work Area: ____________________________

Address: ____________________________

City____________________________  State ______________________  ZIP _____________

Contact Phone Number: ____________________________

Alternate Contact Phone Number: ____________________________

Email Address: ____________________________
Dear Life Scan Patients,

Experts consider fire fighting and EMS to be among the most stressful of all professions. So stressful that the average first responder has almost three times the incident of heart disease, lung disease, and cancer and dies an average of 12 years before other public employees.

It is our experience that heart attacks, strokes, cancer, and other equally devastating diseases can be prevented through early detection and our Life Scan program is critical to each of you! Our Wellness Program is designed to provide you with a tool to be proactive with your own health. It is a valuable health and fitness assessment concept that is proven to identify major medical conditions before the onset of catastrophic consequences. Since the start of our Life Scan Wellness Program, an alarming number our patients have been identified with elevated heart risk conditions that could lead to a deadly heart attack or stroke as well as the early onset of cancers that have resulted in successful treatment and an unprecedented, high rate of cure. Our early detection program gives you and your families the opportunity for medical intervention before it is too late.

LIFE SCAN WELLNESS PROGRAM

1. **ULTRASOUND:** Life Scan uses ultrasound, an extremely safe way to take “pictures” of arteries and organs. Ultrasound uses sound waves to produce images of the body. Ultrasound does not use any form of radiation. The ultrasound specialists will thoroughly discuss the results of each different test with you. The exam will evaluate the different organs for tumors, masses, cysts, enlargements, organ failure, and other critical conditions. The organs include the thyroid, liver, pancreas, gall bladder, spleen, kidneys, bladder, and reproductive organs. The exam will also evaluate the heart for overall heart and valve function, efficiency, size, motion, and for potential carotid artery blockages and the aortic for aneurysms.

2. **CARDIOPULMONARY/FITNESS EVALUATION:** Our exercise physiologist will perform a pulmonary function test to assess your lung capacity for respiratory health. This test helps determine if you are able to wear a respirator for job-related duties, it also is critical in the analysis of lung-related health conditions such as asthmas, bronchial conditions, and pulmonary diseases.

   Our exercise physiologist will evaluate your cardiac status with a resting EKG and cardiac stress test. The stress test is the Gold Standard in the detection of coronary heart conditions as well as cardiovascular fitness levels.

   After evaluating your cardiovascular condition, we will assess your functional capacity levels such as muscular strength, endurance, and flexibility and discuss your diet and nutritional habits. They will then propose a personal “Fitness Prescription” based upon your fitness, diet, cardiovascular, and exercise needs.

3. **PHYSICAL EXAM:** The Life Scan comprehensive physical combines the results from the Ultrasound and Cardio-Pulmonary testing to evaluate your total health status. You will receive an extensive “head-to-toe” physical exam that focuses on an in-depth assessment of medical conditions, blood work analysis, blood pressure, vision, and hearing. You will receive education on existing and potential medical problems, health risks, stress factors, diet, and overall recommendations for medical interventions and/or healthy lifestyle changes.

The cornerstone of the Life Scan Wellness Program is based upon the premise that “Knowledge is Power.” Understanding your own health and knowing the steps you can take to get healthy and stay healthy will change the course of your health legacy. The Life Scan medical team can give you this knowledge and provide you critical medical advice. However, your health depends on what you do with this knowledge. We encourage you to follow the advice and recommendations of your Life Scan medical team. Please feel free to call me if you have any questions about your Life Scan Wellness Program.

Take charge of your own health. Make it your priority…it could save your life!

Patricia Johnson, CEO
In an effort to provide you with the most extensive wellness program to you there are several requirements that must be met prior to your visit.

❖ **Blood work:**
  - Fasting Required: Minimum 8 hours
  - You may drink water.
  - Take your medications as normal.

❖ **Life Scan appointment requirements:**
  - Wear athletic clothes and shoes.
  - Women: Sports bra is recommended.
  - Complete all forms provided in your packet prior to your Life Scan appointment.
  - Please fast for your Life Scan appointment.
    ✓ If your Life Scan appointment is before 1:00 pm please **DO NOT** eat anything after midnight.
    ✓ If your Life Scan appointment is after 1:00 pm you may eat a small, light breakfast and any non-carbonated beverage **BEFORE 8:00 am**.
    ✓ You must have a full urinary bladder in order to visualize certain areas of the body. Please drink 20+ ounces of water at least 45 minutes prior to your appointment time.

❖ **No Tobacco use 4 hours prior to your Life Scan appointment.**

❖ **Hazmat Physicals: Do not eat seafood or shellfish 72 hours before blood draw.**

❖ **Reminder:** You will receive your blood work and X-ray results at the time of your physical exam. Any patient that does not attend a physical will not receive blood work or x-ray reports.

In order to provide you with the most comprehensive health-assessment program available, we ask that you follow the directions provided in your packet completely. If there is any reason why you cannot complete the indicated requirements, health or otherwise, please notify our staff by phone as soon as possible.

Thank you very much. We look forward to seeing you!
# Life Scan
Wellness Center

## Confidential History & Health Risk Appraisal

**Patient Name** __________________________  **DOB** ____________  **Date** ____________

### Symptoms

**GENERAL**
- Chills
- Dizziness
- Fainting
- Fears
- Forgetfulness
- Frequent Headaches
- Weight loss > 10lbs
- Nervousness
- Numbness
- Sweats
- Weight gain > 10lbs

**MUSCLE/Joint/Bone**
- Pain, Weakness, Numbness
  - Arms
  - Back
  - Legs/Knees
  - Feet
  - Neck
  - Hands
  - Shoulders

**SKIN**
- Bruise easily
- Rash/Hives
- Itching
- Change in moles
- Sore that won’t heal

**GASTROINTESTINAL**
- Appetite poor
- Bowel changes
- Frequent constipation
- Frequent Diarrhea
- Excessive hunger
- Excessive thirst
- Excessive gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting blood
- Severe heartburn

**CARdiovascular**
- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

**Eye, Ear, Nose, Throat**
- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent Cough
- Ringing in ears
- Sinus problems
- Vision – Flashes
- Vision – Halos

**Genito-urinary**
- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination
- Sexual Concerns

**Other concerns:**

---

**Do you feel pain in your chest when you do physical activity?**  
☐ Yes  ☐ No  
**Please explain:**

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**Conditions**  
(that you currently have or have had in your lifetime)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Chicken Pox</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Anemia</td>
<td>Depression</td>
</tr>
<tr>
<td>Anorexia</td>
<td>Emphysema</td>
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<tr>
<td>Anxiety</td>
<td>Epilepsy</td>
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<tr>
<td>Appendicitis</td>
<td>Glaucoma</td>
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<tr>
<td>Arthritis</td>
<td>Goiter</td>
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<tr>
<td>Asthma</td>
<td>Gonorrhea</td>
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<tr>
<td>Asthma</td>
<td>Gout</td>
</tr>
<tr>
<td>Bleeding Disorders</td>
<td>Heart Disease</td>
</tr>
<tr>
<td>Breast Lump</td>
<td>Hepatitis</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>Herpes</td>
</tr>
<tr>
<td>Bulimia</td>
<td>High Blood Pressure</td>
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<tr>
<td>Cancer</td>
<td>High Cholesterol</td>
</tr>
<tr>
<td>Cataracts</td>
<td>HIV Positive</td>
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<tr>
<td>Chemical Dependency</td>
<td>Kidney Disease</td>
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<td></td>
<td>Liver Disease</td>
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<tr>
<td></td>
<td>Measles</td>
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<td></td>
<td>Migraine Headaches</td>
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<td></td>
<td>Miscarriage</td>
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<td>Mononucleosis</td>
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<td></td>
<td>Multiple Sclerosis</td>
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<td></td>
<td>Mumps</td>
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<td></td>
<td>Neuromyalgia</td>
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<td></td>
<td>Pacemaker</td>
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<td>Panic-disorder</td>
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<td>Pneumonia</td>
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<td>Polio</td>
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<td></td>
<td>Polymyalgia</td>
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<tr>
<td></td>
<td>Prostate Problem</td>
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<tr>
<td></td>
<td>Psychiatric Care</td>
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<td></td>
<td>Rheumatic Fever</td>
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<td></td>
<td>Scarlet Fever</td>
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<tr>
<td></td>
<td>Stroke</td>
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<td></td>
<td>Suicide Attempt</td>
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<td></td>
<td>Thyroid Problems</td>
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<td></td>
<td>Tonsillitis</td>
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<td></td>
<td>Tuberculosis</td>
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<td></td>
<td>Typhoid Fever</td>
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<tr>
<td></td>
<td>Ulcers</td>
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<td></td>
<td>Vaginal infections</td>
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<tr>
<td></td>
<td>Venereal Disease</td>
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<tr>
<td></td>
<td>Warts</td>
</tr>
</tbody>
</table>

**Tests and Procedures:**

(Please indicate most recent approximate date/year.)

<table>
<thead>
<tr>
<th>Test</th>
<th>Approx Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Exam</td>
<td></td>
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<tr>
<td>Dental Exam</td>
<td></td>
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<tr>
<td>Exercise Stress Test</td>
<td></td>
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<tr>
<td>Colonoscopy/Flexible Sigmoidoscopy</td>
<td></td>
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<tr>
<td>Stool Test (for blood)</td>
<td></td>
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<tr>
<td>Digital Rectal Exam (prostate check)</td>
<td></td>
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<tr>
<td>Chest X ray</td>
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<tr>
<td>TB Test</td>
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<tr>
<td>Mammmogram</td>
<td></td>
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<tr>
<td>Pap Smear (women)</td>
<td></td>
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</tbody>
</table>

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### FAMILY HISTORY

Have parents, siblings, grandparents had any of the following? (If adopted and history unknown, check here _____)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis/Gout</td>
<td></td>
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<td></td>
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<tr>
<td>Asthma</td>
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<td></td>
</tr>
<tr>
<td>Cancer (type)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical Dependency</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Diabetes</td>
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<td></td>
<td></td>
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<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Heart attack before 55</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If either parent or sibling is deceased, Please list relationship to you, age at death, and cause of death.

<table>
<thead>
<tr>
<th>Hospitalizations, Surgeries &amp; Major Illness or Injuries (other than normal vaginal childbirth)</th>
<th>Women: Number of Pregnancies: ____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>Hospital/Injury/Surgery</td>
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<tr>
<td>------</td>
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</tbody>
</table>

Weeks of gestation:

**Social History/Health Habits**

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever smoked?</td>
<td>(if no skip to #6)</td>
</tr>
</tbody>
</table>

**Occupational**

<table>
<thead>
<tr>
<th>Occupation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbers of years at current position?</td>
</tr>
<tr>
<td>Number of years at current position?</td>
</tr>
</tbody>
</table>

**Medications**

<table>
<thead>
<tr>
<th>Number of years with current occupation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. When did you stop smoking?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of packs per day</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

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<thead>
<tr>
<th>Number of years with current occupation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. When did you stop smoking?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of packs per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of packs per day</td>
</tr>
</tbody>
</table>

7. How many times a (Day/Week/Month) do you eat out at Fast foods? /D/W/M

**Vitamins and Supplements**

<table>
<thead>
<tr>
<th>Number of glasses/bottles of water do you drink per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Do you exercise?</td>
</tr>
<tr>
<td>何 often?</td>
</tr>
</tbody>
</table>

I certify that the above information is correct to the best of my knowledge. I will not hold Life Scan or any members of the Life Scan staff responsible for any errors or omission that I may have made in the completion of this form.

Signature: ___________________________ Date: ___________________________

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

If you are planning to significantly increase your physical activity, 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 physically active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each on honestly.

YES NO

☐ ☐ 1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
☐ ☐ 2. Do you feel pain in your chest when you do physical activity?
☐ ☐ 3. In the past month, have you had chest pain when you were not doing physical activity?
☐ ☐ 4. Do you lose your balance because of dizziness or do you ever lose consciousness?
☐ ☐ 5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
☐ ☐ 6. Is your doctor currently prescribing drugs (i.e., water pills) for you blood pressure or heart condition?
☐ ☐ 7. Do you know of any other reason why you should not do physical activity?

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 want to participate 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.

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
- You are or may become pregnant—talk to your doctor before you start becoming more active.

Please Note: If your health changes so that you answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.
LIFE SCAN
Wellness Center

PERSONAL GOALS

In order for us to improve your fitness, it is beneficial for us to know what areas you are of most importance to you. Please answer the questions below as honestly as possible.

Body Weight
- Current Body Weight: ______
- Goal Body Weight: ______

Please state your fitness goals: ________________________________________________________________

Please state your nutrition goals: ______________________________________________________________

Please state your stress management goals: ______________________________________________________

Please state any other goals you have that relate to health: _________________________________________

NUTRITION QUESTIONNAIRE

Typical weekday meals:
- Breakfast: ______________________________________________________________
- Lunch: ________________________________________________________________
- Dinner: ________________________________________________________________
- Snacks: ________________________________________________________________

Typical weekend meals:
- Breakfast: ________________________________________________________________
- Lunch: ________________________________________________________________
- Dinner: ________________________________________________________________
- Snacks: ________________________________________________________________

Please state what time of day you typically find yourself snacking:
- I don’t snack
- Morning
- Afternoon
- Evening

Daily liquid intake (Number of 8 oz glasses you typically consume):
- Water: ______
- Juice: ______
- Diet Soda: ______
- Decaf Coffee: ______
- Unsweetened Tea: ______
- Milk: ______
- Soda: ______
- Coffee: ______
- Sweet Tea: ______
- Sport Drinks: ______

.
LIFE SCAN
Wellness Center

Activities Questionnaire

Do you consider yourself to be:
☐ Sedentary (little, if any, vigorous physical activity)
☐ Lightly active (sporadic workouts, lawn work, other kinds of activity; little aerobic)
☐ Moderately active (work out 1-2 days/week for at least 15-30 min/day; aerobic work)
☐ Highly active (work out three or more days/week, at least 30-45 min/day; aerobic work)

How many minutes per week do you spend in exercise?
☐ 0   ☐ 1-15   ☐ 16-30   ☐ 31-60
☐ 61-90 ☐ 91-120 ☐ 121-180 ☐ 181 and above

Do you do any type of weight training?
☐ Yes   ☐ No

Do you do any type of cardiovascular training?
☐ Yes   ☐ No

Do you believe you are physically fit?
☐ No ☐ Average fitness ☐ Outstanding fitness
☐ Less than average fitness ☐ Above Avg. Fitness ☐ Don’t know

At the job do you sit, more than you are on the move?
☐ Yes   ☐ No

Indicate the main or major reasons why you exercise. Select one.
☐ I do not exercise ☐ It is good for my health ☐ It makes me feel good
☐ I am required to exercise ☐ I’m trying to lose weight ☐ Ordered by physician
☐ Other: ____________________________

Do you know what cardiovascular training and strength training mean?
☐ Yes   ☐ No

If “yes” please explain your interpretation:
_____________________________________________________________________________________
_____________________________________________________________________________________

Using your understanding, discuss what aerobic training involves: _____________________________
_____________________________________________________________________________________

Using your understanding, discuss what strength training involves: ___________________________
_____________________________________________________________________________________

List examples of aerobic activities: _______________________________________________________
List examples of strength training activities: ________________________________________________
Readiness to Change Questionnaire

Research has indicated that an individual’s readiness to change a particular behavior is a staged process. The stages of readiness are as follows:

1. Pre-contemplation (I won’t or can’t change in the next 6 months)
2. Contemplation (I may change in the next 6 months)
3. Preparation (I will change next month)
4. Action (I am doing it now)
5. Maintenance (I’ve been changing for 6 months)

We would like to help you determine how ready you are to change a particular behavior. Please fill out the following form so that we can help you make that change. Select the appropriate stage of readiness for the categories below or list any additional areas you would like to change:

<table>
<thead>
<tr>
<th>Category</th>
<th>Readiness Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Loss</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Improve Dietary Habits</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Quite smoking/ chewing tobacco</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Reduce alcohol consumption</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Start an exercise program</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Improve sleep patterns</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Stress reduction</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Other:</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>______________________________</td>
<td>1 2 3 4 5</td>
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<td>______________________________</td>
<td>1 2 3 4 5</td>
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<tr>
<td>______________________________</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
STRESS AND WELLNESS ASSESSMENT

As part of this wellness program, you are being challenged to consider the undeniable relationship between the mind and body. This Process is “one” in nature, and notes that nothing, absolutely nothing, be experienced in either region without a direct impact on the other. This being said let me encourage you to take just a few minutes to examine the following information. It is intended as a guide to serve you in your self-awareness regarding stress and wellness.

First, review some of the most common “Signs and Symptoms of Tension and Anxiety.” Perhaps these will alert you to any possible concerns you may be having presently or have experience in the past.

SIGNS AND SYMPTOMS OF TENSION AND ANXIETY

1. Getting irritable of petty things
2. Irritability that turns to uncontrollable anger outbursts
3. Becoming hypercritical of others
4. Increasingly feeling sorry for yourself
5. Trouble falling asleep
6. Too busy to eat
7. Having trouble staying asleep
8. Too tired to think or reflect
9. Becoming a nonstop talker
10. Conversing becomes difficult
11. Need to be first in most things
12. Minor disappointments become major setbacks
13. Too much to do and too little time to do it in
14. Unable to stop worrying
15. Boredom
16. Feeling neglected or left out
17. A feeling of being indispensable
18. Feeling trapped
19. Feeling like running a way
20. Anxious about future
21. Hands tremble
22. Laugh or cry for no apparent reason
23. Worry about aches and pains
24. Excessive perspiration
25. Queasy or knotted stomach
26. Light headedness or dizzy spells
27. Need for tranquilizer or drink before facing a decision-need one to relax later

Second, examine the “Holmes-Rahe Stress Scale” on the following pages to determine if you have experienced any of these life events during the previous two years. If an event has occurred more than once during this time period, then multiply the points by the number of times. Thus if you were divorced twice during the two-year time frame, then the score for “Divorce” is 2x73=146. Add all the points to arrive at the total score. Now, review your total score on the social readjustment rating to further clarify how much these life events have impacted you.
HOLMES-RAHE STRESS SCALE
The Social Readjustment Rating

<table>
<thead>
<tr>
<th>LIFE EVENT</th>
<th>POINTS</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death of a spouse</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Divorce</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>Marital Separation</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Jail Term</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>Death of a Close Family Member</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>Personal Injury or Illness</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>Marriage</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Fired At Work</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Marital Reconciliation</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>Retirement</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>Change in health of family member</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Sex Difficulties</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>Addition to Family</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>Business Readjustment</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>Change in Financial State</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>Death of a close friend</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>New line of work</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Change in # of marital arguments</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Mortgage Loan (House)</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Foreclosure</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Change in work responsibilities</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Son or Daughter leaving home</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Trouble with in laws</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Outstanding Personal Achievement</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Spouse Begins or Stops Work</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Beginning or Ending School</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Change In Living Conditions</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Revision of Personal Habits</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Trouble with Boss</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Change in Work Hours or Conditions</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Change in Residence</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Change in Schools</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Change in Recreation</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Change in Church Activities</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Change in Social Activities</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Small Loan (automobile)</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Change in Sleeping Habits</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Change in Eating Habits</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Vacation</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Christmas Season</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Minor Violation Of The Law (Traffic Ticket)</td>
<td>11</td>
<td></td>
</tr>
</tbody>
</table>

TOTAL SCORE

An astonishing correlation is noticed between high life-change scores or social readjustment ratings and risk of medical illness. Eighty percent of the people who score over 300 developed serious ailments during the following year. Major illness occurs in fifty-three percent of those with scores of 150-300, and thirty-three percent of those with scores below 150 develop major illness. Therefore, there is a “physiological price tag” carried on all significant life events. These findings are noted in the 1967 edition, 11th volume, and pages 213-218, of the Journal of Psychosomatic Research.
OSHA Respirator Medical Evaluation Questionnaire

(Mandatory). –1910.134 App C

This form is for OSHA respirator clearance. All employees must fill this form out completely and bring it to your Life Scan appointment. If you use a Scott Air Pack you must also fill you the additional information as stated.

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

To the 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. Today's date:___________________________________________________________
2. Your name:___________________________________________________________ID#________
3. Your age (to nearest year):____________________________________________
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 (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?
   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 slight 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 (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?
   
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
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:)
   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 eardrum: 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
Instructions for Blood Work

Please complete the following information PRIOR to having your blood drawn. Please print the following information on the copied LabCorp Requisition form in the spaces provided.

Please DO NOT include your address, social security, or insurance information.

- NAME (Last name, first name)
- DATE OF BIRTH
- CONTACT PHONE NUMBER
- SEX

**Fast 8-10 hours prior to having your blood drawn.** Fasting is necessary in order to have an accurate cholesterol reading. You may drink water only. No lemon, sugar or any other additives. If you are currently taking any type of medications, please take them at the prescribed times.

**Hazmat: Do Not Eat seafood or shellfish 72 hours prior to blood draw.**

You may use any LabCorp Patient Service Centers in Florida.

You do not need an appointment to have your blood drawn.

You may make an online appointment with LabCorp that will greatly reduce your wait time at the Patient Service Center.

TO FIND A LOCATION AND TO MAKE AN ONLINE APPOINTMENT FOR BLOOD DRAWS:
https://www.labcorp.com/wps/portal/patient/appointment

Enter in your zip code.
You will be prompted to select reason for testing.
Please Select:

*Routine Clinical Laboratory Collection*