LIFE SCAN
Wellness Centers

City of Tampa
Florida

EMPLOYEE PREVENTION & WELLNESS PHYSICALS PATIENT PACKET

Please complete your patient packet and bring it with you to your Life Scan physical

LIFE SCAN WELLNESS CENTERS

City of Tampa Employee
Prevention & Wellness Physicals

LIFE SCAN WELLNESS PROGRAM

Comprehensive Medical Exam

- *Firefighter Physical Exam*
- *Vital Signs*
- *Vision and Hearing*
- *Skin Cancer assessment*
- *Consultation with review of results, recommendations, and a personalized health plan*

Ultrasound Imaging

- *Echocardiogram (Heart with function)*
- *Carotid Arteries*
- *Aorta and Aortic Valve*
- *Liver, Pancreas, Gall Bladder, Kidneys, and Spleen (Internal Organs)*
- *Ovaries/Uterus*
- *Testicular/Prostate*
- *Bladder*
- *Thyroid*

Cardio Pulmonary:

- *Cardiac Exercise Stress Test with EKG*
- *Electrocardiogram*
- *Pulmonary Function Test*

Laboratory Analysis:

- *Comprehensive Metabolic Panel*
- *Complete Blood Count*
- *Lipid Panel (cholesterol)*
- *Thyroid Panel*
- *Hemoglobin A1C and Glucose*
- *Urinalysis*
- *Occult Blood Study*
- *Men: PSA Prostate Cancer Marker*
- *Men: Testosterone Levels*
- *Women: CA-125 Ovarian Cancer Marker*
- *Hepatitis C*
- *QuantiFeron Gold for TB*

Fitness Analysis

- *Metabolic Analysis*
- *Strength Testing*
- *Endurance Evaluation*
- *Flexibility Test*
- *Diet and Nutritional Recommendations*
- *Personal Exercise Prescription*

PROTECT YOUR HEALTH!

The Life Scan 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, v isualizes 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
Pamela Desmarais ARNP, Clinical Director

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Our confidential 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. It is our experience that heart attacks, strokes, cancer, and other equally devastating diseases can be prevented through early detection! Our early detection program gives you and your family the opportunity for medical intervention before it is too late!

LIFE SCAN WELLNESS PROGRAM

There are three parts to your Life Scan appointment that include Ultrasound Imaging, Physical Exam, and Cardiopulmonary/Fitness Evaluation.

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 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, heart, liver, pancreas, gall bladder, spleen, kidneys, bladder, and reproductive organs. The exam will also evaluate overall heart and valve function, efficiency, size, motion, and for potential carotid artery blockages and the aorta 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. They will also evaluate your heart activity with a resting electrocardiogram and cardiac stress test. Your functional capacity levels such as muscular strength, endurance, and flexibility and discuss your diet and nutritional habits will then be assessed. 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 Life Scan's medical team. **Take charge of your own health. Make it your priority…it could save your life!**

Sincerely,

Patricia Johnson

Patricia Johnson
CEO/President
Life Scan Wellness Centers

LIFE SCAN
Wellness Centers

Dear Life Scan Patient,

Welcome to the Life Scan Wellness Program!

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 Draws: Must be done at least 5 days prior to your Life Scan appointment**
  - You must bring your Requisition form to the draw station, which is provided in your packet. Fill out Name, Birth Date, Department name in the ID box and Phone Number BEFORE GOING TO THE LABCORP.
  - Any Labcorp Patient Service Center.
  - There is no appointment needed to have your blood drawn at the Labcorp Laboratory.
  - Fasting Required: Minimum 8 hour
    - ✓ You may drink water
    - ✓ Take your medications as normal.
  - Labs will not be reviewed until time of appointment. It is the patients' responsibility to contact Life Scan for results on labs if appointment is missed.

- **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.**

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!

Pamela Desmarais
ARNP Clinical Director

Please read all included material. If you any questions, call our office at
Tampa: (813) 876-0625

LIFE SCAN
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Patient Name: _____
Last First Middle Initial

Patient SS# or Employee ID#: _____

Birth Date: _____ Age _____ Circle One: Male Female

Employer: _____

Position or Title: _____ Station or Work Area: _____

Exam Date: _____

Current Estimated Weight: _____lbs. Height: _____ft._____ in.

Address: _____

City_____ State _____ ZIP _____

Contact Phone Number: _____

Alternate Contact Phone Number: _____

Email Address: _____

Can we send you your results via email? Yes___ No ____

Primary Care Physician _____ Phone _____

Street Address _____

City_____ State _____ Zip _____

Physician _____ Specialty _____ Phone _____

Physician _____ Specialty _____ Phone _____

☐YES ☐NO I authorization Life Scan to release my medical records to my personal email address and/or medical provider.
Signature _____ Date _____

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CONFIDENTIAL HISTORY & HEALTH RISK APPRAISAL

Patient Name_____ **DOB**_____ **Date**_____

Allergies (food, drug etc) _____

Symptoms **Check symptoms you currently have or have had in the past year.**

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

MUSCLE/JOINT/BONE
Pain, Weakness, Numbness
- ☐ Arms ☐ Hips
- ☐ 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

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in Testicles
- ☐ Penis discharge
- ☐ Sore on penis

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Endometriosis
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Infertility
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ PMS
- ☐ Abnormal Vaginal discharge

Date of last Menstrual period _____

Are you pregnant?_____

Number of Children _____

Other Concerns:

Conditions **you currently have or have had in your lifetime**
- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Anxiety
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Depression
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Neuromyalgia
- ☐ Pacemaker
- ☐ Panic-disorder
- ☐ Pneumonia
- ☐ Polio
- ☐ Polymyalgia
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal Disease
- ☐ Warts

TESTS AND PROCEDURES:

(Please indicate most recent approximate date/year.)

Test	**Approx Date**
☐ Physical Exam	
☐ Dental Exam	
☐ Exercise Stress Test	
☐ Colonoscopy/Flexible Sigmoidoscopy	
☐ Stool Test (for blood)	
☐ Digital Rectal Exam (prostate check) - Male	
☐ Chest X ray	
☐ TB Test	
☐ Mammogram	
☐ Pap Smear -Female	

Do you feel pain in your chest when you do physical activity? ☐ Yes ☐ No (if yes please explain)_____

FAMILY HISTORY

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

	Yes	No	Relationship		Yes	No	Relationship
Arthritis/Gout				High Blood Pressure			
Asthma				High Cholesterol			
Cancer (type)				Kidney Disease			
Chemical Dependency				Liver Disease			
Diabetes				Mental Illness			
Heart Disease				Tuberculosis			
Heart attack before 55				Other			

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

Hospitalizations, Surgeries & Major Illness or Injuries (other than normal vaginal childbirth)

Year	Hospital/ Injury/Surgery	Reason for Hospitalization and Outcomes

Occupational

Occupation:

Numbers of years at current position?

Number of years with current occupation?

Medications (state reason for taking medication)

Vitamins and Supplements

Women: Number of Pregnancies: ____

Current method of contraception:

Year of Birth:	Gender:	Complications, if any:

Weeks of gestation:

Social History/Health Habits

	Y	N	
Have you ever smoked?			Chew? Yes / No
Number of years you smoked?			Number of years chewed?
Do you currently smoke?			
Number of packs per day			
When did you stop smoking?			
Do you drink beer, hard liquor, or wine?			Number of years

Beer _____**cans**/**ounces**/**glasses** per **day**/**week** (circle which ever applies)

Liquor ____ **cans**/**ounces**/**glasses** per **day**/**week** (circle which ever applies)

Wine _____ **cans**/**ounces**/**glasses** per **day**/**week** (circle which ever applies)

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

Do you consume Caffeine beverages?			(specify amount below)
Coffee?			Soda/soft drinks?
Tea? (unsw/sw)			Energy Drinks?
How many oz/glasses/bottles of water do you drink per day?			
Do you exercise?			How often?

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: _____

PATIENT HEALTH SCREENING QUESTIONNAIRE

Name:_____ Age: _____ Gender : M F

Height: _____ Weight: _____ lbs. Goal weight: _____ lbs.

Stage 1 - Known Diseases (Medical Conditions)

-List the medications you take on a regular basis. _____

-Do you have diabetes?.....No Yes

a) if yes, please indicate if it is insulin-dependent diabetes mellitus (IDDM) or non-insulin-dependent diabetes mellitus (NIDDM)….IDDM NIDDM

b) if IDDM, for how many years have you had IDDM?_____ years

-Have you had a stroke? ..... No Yes

-Has your doctor ever said you have heart trouble? ..... No Yes

-Do you take asthma medication? .....No Yes

-Are you or do you have reason to believe you may be pregnant? ..... No Yes

-Is there any other physical reason that prevents you from participating in an exercise program (e.g. cancer; severe arthritis, kidney or liver disease)? ..... .No Yes

Stage 2 - Signs and Symptoms

-Do you often have pains in your heart, chest, or surrounding areas, especially during exercise?..... No Yes

-Do you often feel faint or have spells of severe dizziness during exercise? ..... No Yes

-Do you experience unusual fatigue or shortness of breath at rest or with mild exertion?..... No Yes

-Have you had an attack of shortness of breath that came on after you stopped exercising? ..... No Yes

-Have you been awakened at night by an attack of shortness of breath?..... No Yes

-Do you experience swelling or accumulation of fluid in or around your ankles? No Yes

-Do you often get the feeling that your heart is beating faster, racing, or skipping beats, either at rest or during exercise? ..... No Yes

-Do you regularly get pains in your calves and lower legs during exercise which are not due to soreness or stiffness?..... No Yes

-Has your doctor ever told you that you have a heart murmur?..... No Yes

Stage 3 - Cardiac Risk Factors

-Do you smoke cigarettes daily, or have you quit smoking within the past two years?.No Yes

If yes, how many cigarettes per day (or did you smoke in the past two years)?_____/day

-Has your doctor ever told you that you have high blood pressure…… .No Yes

-Has your father, mother, brother, or sister had a heart attack or suffered from cardiovascular disease before the age of 55?..... No Yes

a) If yes,Was the relative male or female?_____

b) At what age did he or she have the stroke or heart attack? _____

c) Did this person die suddenly as a result of the stroke or heart attack?..... No Yes

-Have you experienced menopause before the age of 45?..... …… No Yes

If yes, do you take hormone replacement medication?..... .No Yes

Stage 4 - Exercise Intentions

Does your job involve sitting for a large part of the day?..... No Yes

What are your current activity patterns?

a) Frequency: _____ exercise sessions per week

b) Intensity: Sedentary Moderate Vigorous

c) History: <3 months 3-12 months >12 months

d) Duration: _____ minutes per session

What types of exercises do you do?: _____

Do you want to exercise at a moderate intensity (e.g. brisk walking) or at a vigorous intensity (e.g. jogging)?.....Moderate Vigorous

Typically on regular day I eat:

__ Breakfast
__Snack
__Lunch
__Snack
__Dinner
__Snack

Typical **Work Day** diet

_____
_____
_____
_____
_____
_____
_____
_____

Typical **Work Day** drinks

_____
_____
_____

Typical **Off Day** diet

_____
_____
_____
_____
_____
_____
_____
_____

Typical **Off Day** drinks

_____
_____
_____

REVIEWED BY LIFE SCAN EXERCISE PHYSIOLOGIST _____ DATE_____

PATIENT HEALTH QUESTIONNAIRE - PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(circle 0 - 3 to indicate your answer)

	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
ADD COLUMNS				

TOTAL OF ALL COLUMNS _____
(add all columns)

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
(Circle answer below)

Not difficult at all Somewhat Difficult Very difficult Extremely difficult

Reviewed by Nurse Practitioner _____ Date _____

Comments

_____

_____

_____

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

(Only required for certain employees based on respirator use)

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

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.

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

Today's date:_____ Name:_____ ID#_____

Age (to nearest year):_____ Sex (circle one): Male/Female Height: _____ ft. _____ in. Weight: _____ lbs. job

Job Title:_____ Phone Number _____

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).

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
a. Pain or tightness in your chest during physical activity: Yes/No
b. Pain or tightness in your chest that interferes with your job: Yes/No
c. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No
d. Heartburn or indigestion that is not related to eating: Yes/ No
e. 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?
b. Breathing or lung problems: Yes/No
c. Heart trouble: Yes/No
d. Blood pressure: Yes/No
e. 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).

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

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INSTRUCTIONS FOR BLOOD WORK

(attached in separate file)

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

Fill in the following information on your Lab Corp requisition:

- **PATIENT LAST NAME**
- **PATIENT FIRST NAME**
- **DOB**
- **GENDER**
- **PATIENT PHONE NUMBER**

DO NOT EAT 8-10 hours prior to having your blood drawn. Fasting is necessary in order to have an accurate cholesterol and glucose 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. If you are unable to fast due to any type of medical condition or medication you are currently taking, please notify Life Scan.

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

You may make an online appointment with Labcorp:
https://www.labcorp.com/wps/portal/patient/appointment
Enter in your zip code. You will be prompted to select reason for testing:
Routine clinical laboratory collections

You can find Labcorp locations near you:
https://www.labcorp.com/wps/portal/patient/findalab

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LABCORP PATIENT SERVICE CENTERS
IN THE TAMPA BAY AREA

2727 W DR MLK BLVD STE 200
TAMPA, FL 33607
813-877-7110

5610 W LA SALLE ST
TAMPA, FL 33607
813-289-5227

11916 SHELDON RD STE C
TAMPA, FL 33626
813-920-6332

15423 N DALE MABRY HWY STE 101
TAMPA, FL 33618
813-963-7838

14438 UNIVERSITY COVE PL
TAMPA, FL 33613
813-972-9515

427 S PARSONS AVE STE 120
BRANDON, FL 33511
813-681-7184

11370 66TH ST STE 125
LARGO, FL 33773
727-545-0076

8745 STATE ROAD 54
NEW PORT RICHEY, FL 34655
727-376-2718

2981B W BAY DR BELLEAIR
BLUFFS, FL 33770
727-586-2686

607 S ALEXANDER ST STE 107 110
PLANT CITY, FL 33563
813-719-7944

1822 N BELCHER RD 101 102
CLEARWATER, FL 33765
727-442-3671

29245 US HWY 19 NORTH
CLEARWATER, FL 33761
727-785-1419

3909 GALEN CT STE 101
SUN CITY CENTER, FL 33573
813-634-2797

33 6TH ST S STE 110
SAINT PETERSBURG, FL 33701
727-821-5801

5653 PARK ST N STE 2
SAINT PETERSBURG, FL 33709
727-547-9677

4105 49TH ST N STE B
SAINT PETERSBURG, FL 33709
727-525-1310

1550 BLOOMINGDALE AVE
VALRICO, FL 33596
813-681-5311

1724 BRUCE B DOWNS BLVD STE Q2
WESLEY CHAPEL, FL 33544
813-907-0861