HealthPartners®

Mobile Equipment Operator (MEO) Questionnaire

Employee Name: _____

Employer _____ Forklift/PIT Driver ❑Yes ❑No Crane Operator ❑Yes ❑No

Type of Forklift/PIT/Crane Operated _____

The following information will be used to determine your fitness to operate a Powered Industrial Truck or Crane. **Please explain "Yes" answers in comment section.** Indicate whether you have now or ever had the following:

YES	NO		YES	NO	
❑	❑	Any illness or injury in the last 5 years?	❑	❑	Fainting, dizziness, light-headedness
❑	❑	Head/Brain injuries, disorders or illnesses	❑	❑	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring, sleep apnea
❑	❑	Seizures, epilepsy			
		❑ Medication_____	❑	❑	Stroke or paralysis
❑	❑	Eye disorders or impaired vision (except corrective lenses)	❑	❑	Missing or impaired hand, arm, foot, leg, finger, toe
			❑	❑	Spinal injury or disease
❑	❑	Ear disorders, loss of hearing or balance	❑	❑	Chronic low back pain, neck or shoulder pain
❑	❑	Heart disease or heart attack; arrhythmias, other cardiovascular condition	❑	❑	Regular, frequent alcohol use
			❑	❑	Narcotic or habit forming drug use
		❑ Medication_____	❑	❑	Diabetes or elevated blood sugar controlled by:
❑	❑	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)			❑Diet ❑Pills ❑Insulin
			❑	❑	Nervous or psychiatric disorders, e.g., severe Depression ❑ Medication_____
❑	❑	High blood pressure			
		❑ Medication_____	❑	❑	Loss of, or altered consciousness
❑	❑	Muscular disease	❑	❑	Narcolepsy / Cataplexy
❑	❑	Kidney disease, dialysis	❑	❑	Shortness of breath
❑	❑	Liver disease	❑	❑	Lung disease, emphysema, asthma, chronic bronchitis
❑	❑	Digestive problems	❑	❑	Loss of range of motion in any joint

For and YES answer, indicated onset date, diagnosis, treating physician's name and address, and any current limitations. (May continue on back of this page if needed). **List all medications** (including over-the-counter or herbal supplements) used regularly or recently:_____

_____

I have responded to the above questions to the best of my knowledge. I understand that any future changes in my medical conditions which may affect my fitness and ability to operate a forklift/PIT/crane operator should be reported to the company nurse or safety director.

Employee Signature _____ **Date** _____

PLEASE DO NOT WRITE BELOW SIGNATURE. FOLLOWING FOR OFFICE USE ONLY.

Ht: _____ Wt: _____ B/P: _____ P:_____ R: _____

Vision Test: ❑ Without corrective lenses ❑ With corrective lenses

Distant Rt. 20/ _____ Lt. 20/ _____ Both 20/ _____

Field of Vision: R _____ L_____ Depth _____ Color Vision _____

Hearing: Audiogram ❑ Meets standard ❑ Does not meet standard (less than 40dB loss at .5, 1 & 2 kHz)

Whisper ❑ Meets standard ❑ Does not meet standard (more than 5 feet)

Urine Dipstick Glucose_____

_____ _____

Provider Signature Date

❑ Gary Johnson, MD ❑Robert Gorman, MD ❑Fozia Abrar, MD