Appendix D. Medical Questionnaire for Respirator Users

Name (Last, First, Middle initial):_____
Employee#_____ Work #_____

Division_____ Mail Stop: _____ Job Title_____

Date of Birth _____

RESPIRATOR TYPE: AIR PURIFYING SUPPLIED AIR

☐ Filtering face piece (dusk mask) ☐ Full-Face Mask ☐ Airline (Continuous Flow)

☐ Half-Mask ☐ PAPR ☐ Airline (Pressure Demand) ☐ SCBA

Have you worn a respirator? Yes / No

In order to satisfy Federal OSHA requirements, each individual must be medically approved prior to performing a task while wearing respiratory protective equipment. This questionnaire must be completed even if you have had a recent physical examination in the Health Services Department.

Contaminant(s):_____

The employee listed above is medically able to wear respiratory protection. A copy of this approval has been provided to the employee.

Medical approval: _____ Date: _____

Medical restrictions: _____Date: _____

Employee's signature: _____ Date: _____

Questions 1 through 12 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

10. Have you ever worked with any of the materials or under any of the conditions listed below:

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:

_____

11. List any second jobs or side businesses you have related to chemical use:

_____

12. List your current and previous hobbies related to chemical use:

_____

Questions 13 through 18 must be answered by every employee who has been selected to use either a full-face 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.

13. Have you *ever lost* vision in either eye (temporarily or permanently) Yes / No
14. 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
15. Have you *ever had* an injury to your ears, including a broken ear drum: Yes / No
16. 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
17. Have you *ever had* a back injury: Yes / No
18. 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 respiratory: Yes / No