

Appendix C

Respirator Medical Evaluation Questionnaire

To the employee:

You must be allowed 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. Your supervisor must tell you how to deliver or send this questionnaire to the Health South Clinic physician who will review it.

Part A. The following information must be provided by every employee who has been selected to use any type of respirator (please print).

Section 1. Personal information

1. Today's date: _____
2. Your name: _____

Last	First	Middle Initial
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3. Social Security Number: _____
4. Birthdate: _____
5. Job title: _____
6. Supervisor: _____
7. Department: _____
8. Campus: _____
9. Work phone number: _____
10. Sex (check one): Male Female
11. Your height: _____ ft. _____ in.
12. Your weight: _____ lbs.
13. Has your employer told you how to contact the health care professional who will review this questionnaire? (Check one): Yes No
14. Check the type of respirator you will use (you can check more than one category):
 filter mask (non-cartridge type only)
 half-face
 full-face
 power air purifying respirator (PAPR)
 self contained breathing apparatus (SCBA)
15. Have you ever used a respirator? (Check one): Yes No
 If "yes," what type(s): _____

Section 2. Medical information (Mandatory)

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator

(please check "yes" or "no").

Yes **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?
 - f. Asbestosis Yes No
 - g. Asthma Yes No
 - h. Chronic bronchitis Yes No
 - i. Emphysema Yes No
 - j. Pneumonia Yes No
 - k. Tuberculosis Yes No
 - l. Silicosis Yes No
 - m. Pneumothorax (collapsed lung) Yes No
 - n. Lung cancer Yes No
 - o. Broken ribs Yes No
 - p. Any chest injuries or surgeries Yes No
 - q. Any other lung problem that you have 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 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

- | | <u>Yes</u> | <u>No</u> |
|--------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 5. Have you ever had any of the following cardiovascular or heart problems? | | |
| a. Heart attack | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Angina | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Heart failure | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Swelling in your legs or feet (not caused by walking) | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Heart arrhythmia (heart beating irregularly) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Any other heart problem that you've been told about | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had any of the following cardiovascular or heart symptoms? | | |
| a. Frequent pain or tightness in your chest | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Pain or tightness in your chest during physical activity | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Pain or tightness in your chest that interferes with your job | <input type="checkbox"/> | <input type="checkbox"/> |
| d. In the past two years, have you noticed your heart skipping or missing a beat | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Heartburn or indigestion that is not related to eating | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Any other symptoms that you think may be related to heart or circulation problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you currently take medication for any of the following problems? | | |
| a. Breathing or lung problems | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Heart trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Seizures (fits) | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Are you taking any other medications for any reason (including over-the-counter medications)? | <input type="checkbox"/> | <input type="checkbox"/> |
| If "yes," name the medications if you know them: _____ | | |

8. If you have never used a respirator, check the following box and go to question 9:
- If you have used a respirator, have you ever had any of the following problems?
- | | | |
|--------------------------------------------------------------------|--------------------------|--------------------------|
| a. Eye irritation | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Skin allergies or rashes | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| d. General weakness or fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Any other problem that interferes with your use of a respirator | <input type="checkbox"/> | <input type="checkbox"/> |
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-facepiece 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.

- | | <u>Yes</u> | <u>No</u> |
|----------------------------------------------------------------------------------|--------------------------|--------------------------|
| 10. Have you ever lost vision in either eye (temporarily or permanently)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you: | | |
| a. Wear contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Wear glasses? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have color blindness? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have any other eye or vision problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had an injury to your ears, including a broken eardrum? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you currently have any of the following hearing problems? | | |
| a. Difficulty hearing | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Wear a hearing aid | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Any other hearing or ear problem | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had a back injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you currently have any of the following musculoskeletal problems? | | |
| a. Weakness in any of your arms, hands, legs, or feet | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Back pain | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Difficulty fully moving your arms and legs | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Pain or stiffness when you lean forward or backward at the waist | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Difficulty fully moving your head up or down | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Difficulty fully moving your head side to side | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Difficulty bending at your knees | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Difficulty squatting to the ground | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs. | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Any other muscle or skeletal problem that interferes with using a respirator | <input type="checkbox"/> | <input type="checkbox"/> |

Part B. Respirator use information

- How often and for how long do you use your respirator? (i.e. # of hours per day/week/month) _____
- What type of activities do you perform while wearing your respirator? _____
- List any additional personal protective equipment (e.g., tyvek, gloves, etc.) worn during respirator use: _____
- What are the temperature and humidity extremes (highest & lowest) that may be encountered on your job? _____
- Have you ever worked on a HAZMAT team or with hazardous materials? (Check one): Yes No

Signature _____ Date _____