LAWRENCE UNIVERSITY

Respirator Medical Evaluation Questionnaire

NOTE: OSHA requires that the following be completed during normal working hours or at a time and place convenient to the employee. To maintain confidentiality, your employer or supervisor must not look at or review these answers, and they must tell you how to deliver or send this questionnaire to the health care professional for review.

CAN YOU READ? (circle one) Yes / No SEX (circle one): Male / Female

NAME (PRINT): _____ DATE: _____

JOB TITLE: _____ AGE: _____

YOUR HEIGHT : _____ FT._____ IN. YOUR WEIGHT:_____ LBS.

PHONE # (where you can be reached by the health care professional reviewing this questionnaire): (_____)_____

TIME (the best time to phone you at this number):_____AM / PM

Has your employer told you how to contact the health care professional who reviews this questionnaire? Yes / No
ThedaCare at Work, Dr. Dumas or PLHCP (920) 380-4999
Check the type of respirator you will use (you can check more than one category):

_____ N, R, P disposable respirator (filter mask, non-cartridge type only).

_____ Other type (for example,half- or full-facepiece type, powered-air purifying, supplied-air self-contained breathing apparatus).

Have you worn a respirator? Yes / No If yes, what type(s): _____

PART A (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 mucus): 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 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, circle "No" and go to question 9): Yes / No

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 ten through fifteen 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 selected to use other types of respirators, answering these 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 had an injury to your ears, including a broken ear drum: 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 muskoskeletal 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 the 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

Part B

1. In your present job, are working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen? Yes / No

   If yes, do you have feelings of dizziness, shortness of breath, pounding in the chest, or other symptoms when working under these conditions? Yes / No

2. At home or work, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (gases, fumes, dusts), or have you come into skin contact with hazardous chemicals? Yes / No

   If yes, name the chemicals if you know them: _____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below?

   a. Asbestos: Yes / No
   b. Silica: Yes / No
   c. Tungsten/cobalt (grinding/welding): Yes / No
   d. Beryllium: Yes / No
   e. Aluminum: Yes / No
   f. Coal (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 the exposures: _____

4. List any second jobs or side businesses you have: _____

5. List your current and previous occupations/hobbies: _____

6. Have you been in the military services? Yes / No

   If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes / No

7. Have you ever worked on a HAZMAT team? Yes / No

8. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier, are you taking any other medications for any reason (including over-the-counter)? Yes / No

   If "yes," name the medications if you know them: _____

9. Describe any special responsibilities or hazardous conditions that you may encounter while using the respirator(s) (if none circle): N/A _____

10. If you know, provide the toxic substances, as well as the estimated maximum exposure and duration of exposure per shift:

    _____