UofL Respiratory Protection Program

Respirator Medical Evaluation Questionnaire

OSHA 1910.134 Appendix C

For clinical trainees ONLY

Place completed questionnaire in an envelope, seal and mark CONFIDENTIAL

Deliver or send via Campus Mail to:

Respiratory Medical Clearance
Campus Health Services
401 East Chestnut Street
Louisville, KY 40292

If you have any questions about this medical questionnaire please contact your supervisor or the Respiratory Protection Program Administrator at the Department of Environmental Health and Safety: 852-2961

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To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee: Can you read (check one): ❑ **Yes** ❑ **No**

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 (please print).

1. Today's date: ____

2. Your Name: ____

3. Your Soc. Sec. #:_______________ Employee ID #:______________

4. Your age (to nearest year):_________ Birth Date__________________

5. Sex: ❑ Male ❑ Female

6. Your height: _________ ft. _________ in.

7. Your weight: __________ lbs.

8. Your job title: ____

9. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):_________________

10. The best time to phone you at this number: ______________

11. ❑ **Yes** ❑ **No** Has your employer told you how to contact the health care professional who will review this questionnaire?

12. Check the type of respirator you will use (you can check more than one category):

❑ **Yes** ❑ **No** N, R, or P disposable respirator (filter-mask, non-cartridge type only)
❑ **Yes** ❑ **No** Other type (for example, half- or full-facemask type, powered-air purifying, supplied-air, self-contained breathing apparatus)

13. ❑ **Yes** ❑ **No** Have you worn a respirator before?

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 Check "yes" or "no").

❑ Yes ❑ No	1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month?
Question 2 ➔	2. Have you ever had:
❑ Yes ❑ No	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
Question 3 ➔	3. Have you ever had any of the following pulmonary or lung problems?
❑ Yes ❑ No	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
Question 4 ➔	4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?
❑ Yes ❑ No	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	m. Any other symptoms that you think may be related to lung problems
Question 5➔	5. Have you **ever had** any of the following cardiovascular or heart problems?
❑ Yes ❑ No	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
Question 6 ➔	6. Have you **ever had** any of the following cardiovascular or heart symptoms?
❑ Yes ❑ No	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
Question 7 ➔	7. Do you **currently** take medication for any of the following problems?
❑ Yes ❑ No	a. Breathing or lung problems
❑ Yes ❑ No	b. Heart trouble
❑ Yes ❑ No	c. Blood pressure
❑ Yes ❑ No	d. Seizures (fits)
Question 8 ➔	8. If you've used a respirator, have you **ever had** any of the following problems? (If you've never used a respirator 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 respirato

Questions 9 to 14 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).

For employees who have been selected to use other types of respirators, answering these questions is **voluntary**.

❑ Yes ❑ No	9. Have you **ever lost** vision in either eye (temporarily or permanently)?
Question 10➔	10. Do you **currently** have any of the following vision problems?
❑ Yes ❑ No	a. Wear contact lenses
❑ Yes ❑ No	b. Wear glasses
❑ Yes ❑ No	c. Color blindness
❑ Yes ❑ No	d. Any other eye or vision problem
❑ Yes ❑ No	11. Have you **ever had** an injury to your ears, including a broken ear drum?
Question 11➔	12. Do you **currently** have any of the following hearing problems?
❑ Yes ❑ No	a. Difficulty hearing
❑ Yes ❑ No	b. Wear a hearing aid
❑ Yes ❑ No	c. Any other hearing or ear problem
❑ Yes ❑ No	13. Have you **ever had** a back injury?
Question 12➔	14. Do you **currently** have any of the following musculoskeletal problems?
❑ Yes ❑ No	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	i. Any other muscle or skeletal problem that interferes with using a respirator

Part B

Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

Question 1➔	❑ Yes ❑ No	1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen?
If no go to #2 If Yes, go to 1a ➔	❑ Yes ❑ No	1a. If "**yes**," do you have feelings of dizziness, shortness of breath, pounding in your chest or other symptoms when you're working under these conditions?
Question 2➔	❑ Yes ❑ No	2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals?
If Yes then ➔ If no go to #3	If "**yes**," name the chemicals if you know them: 1. ____________________ 4. ____________________ 2. ____________________ 5. ____________________ 3. ____________________ 6. ____________________	
Question 3 ➔	Have you ever worked with any of the materials, or under any of the conditions, listed below?	
❑ Yes ❑ No	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	
If Yes to 3a – i, then ➔ If no go to #4	If "**yes**," describe these exposures:	
Question 4➔	4. List any second jobs or side businesses you have:	
Question 5➔	5. List your previous occupations:	
Question 6➔	6. List your current and previous hobbies	
Question 7➔	❑ Yes ❑ No	7. Have you been in the military services?
If Yes then ➔ If no go to #8	a. If "yes," were you exposed to biological or chemical agents (either in training or combat)? Please list any agents that you were exposed to:	

Question 8→	❑ Yes ❑ No	8. Have you ever worked on a HAZMAT team?
Question 9→	❑ Yes ❑ No	9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)
If Yes then → If no go to #10	If "**yes**," name the medications if you know them	

Question 10→	10. Will you be using any of the following items with your respirator(s)?
❑ Yes ❑ No	a. HEPA Filters
❑ Yes ❑ No	b. Canisters (for example, gas masks)
❑ Yes ❑ No	c. Cartridges
Question 11→	11. How often are you expected to use the respirator(s)? (check "yes" or "no" for all answers that apply to you)
❑ Yes ❑ No	a. Escape only (no rescue)
❑ Yes ❑ No	b. Emergency rescue only
❑ Yes ❑ No	c. Less than 5 hours **per week**
❑ Yes ❑ No	d. Less than 2 hours **per day**
❑ Yes ❑ No	e. 2 to 4 hours per day
❑ Yes ❑ No	f. Over 4 hours per day

Question 12→	12. During the period you are using the respirator(s), is your work effort:	Examples:
❑ Yes ❑ No	12a. Light (less than 200 kcal per hour)	**sitting** while writing, typing, drafting, or performing light assembly work; or **standing** while operating a drill press (1-3 lbs.) or controlling machines.
If Yes then → If no go to 12. b	How long does this period last during the average shift: _____hrs. _____min	
❑ Yes ❑ No	12b. Moderate (200 to 350 kcal per hour)	are **sitting** while nailing or filing; **driving** a truck or bus in urban traffic; **standing** while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; **walking** on a level surface about 2 mph or down a 5-degree grade about 3 mph; or **pushing** a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.
If Yes above then → If no go to 12. c	How long does this period last during the average shift: _____hrs. _____min	
❑ Yes ❑ No	12c. Heavy (above 350 kcal per hour)	**lifting** a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; **shoveling; standing** while bricklaying or chipping castings; **walking** up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).
If Yes above then → If no go to 13	How long does this period last during the average shift: _____hrs. _____min	

Question 13→	❑ Yes ❑ No	13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator?
If Yes above then → If no go to 14	13a. Describe this protective clothing and/or equipment:	

Question 14➔	❑ Yes ❑ No | 14. Will you be working under hot conditions (temperature exceeding 77 degrees F)
Question 15➔	❑ Yes ❑ No | 15. Will you be working under humid conditions
Question 16➔	16. Describe the work you'll be doing while you're using your respirator(s):
Question 17➔	17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):
Question 18➔	18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Substance	Est. Maximum Exposure/Shift	Duration per Shift (Hours)

The name of any other toxic substances that you'll be exposed to while using your respirator:

Question 19➔	19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security)
Question 20➔	❑ Yes ❑ No | Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

Employee Signature: ____ Date: ______________

Please deliver or send completed questionnaire in a sealed envelope addressed via CAMPUS mail to:

Respiratory Evaluation Program
Campus Health Services
401 East Chestnut Street Suite 110
Louisville, KY 40292

If you have any questions about this medical questionnaire please contact your supervisor or the Respiratory Protection Program Administrator at the Department of Environmental Health and Safety: 852-2961