

APPENDIX E

**MEDICAL
QUESTIONNAIRE FOR
RESPIRATOR USERS**

Shasta County Respiratory Protection Program
Medical Questionnaire for Respirator Users

Employee's Name _____ Date _____

Home address: _____ Department _____

_____ Address: _____

Home Phone #: _____ Work Phone #: _____

Date of Birth: ____ / ____ / ____ Age: _____ Job Title: _____

SSN: _____ Number of Years Worked for the Department. _____

To the Employee: Can you read? (Check one): Yes No

Your Supervisor 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 supervisor 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. Sex (circle one): Male / Female
2. Your height: ____ ft. ____ in.
3. Your weight: _____ lbs.
4. Is it okay for the health care professional who reviews this questionnaire to contact you at one of the telephone numbers listed above? Yes _____ No _____
If No is checked, please list the telephone number where you can be reached. _____
5. What is the best time to reach you at this number? _____
6. Has your supervisor told you how to contact the health care professional who will review this questionnaire? Yes _____ No _____
7. Check the type of respirator you will use (you can check more than one category):
 - a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
 - b. _____ Half- or full-face piece air-purifying type
 - c. _____ Powered-air purifying, supplied-air
 - d. _____ Self-contained breathing apparatus (SCBA)

8. Have you worn a respirator? Yes _____ No _____

If "yes," what type(s):

- a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
- b. _____ Half- or full-face piece air-purifying type
- c. _____ Powered-air purifying, supplied-air
- d. _____ Self-contained breathing apparatus (SCBA)

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 circle "Yes" or "No")

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month: Yes No
a. If yes, what quantity (how many cigarettes per day)? _____
b. If you did smoke tobacco and quit, how long has it been since you last smoked? _____

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 incline: Yes No
c. Shortness of breath when walking with others 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, 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

Part B.

1. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals? Or have you come into skin contact with hazardous chemicals? Yes No

If "yes," circle or name them:

- | | | |
|------------------------------------|-----|----|
| a. Asbestos: | Yes | No |
| b. Silica (e.g., in sandblasting): | Yes | No |
| c. Lead: | Yes | No |
| d. Pesticides: | Yes | No |
| e. Glues and Adhesives: | Yes | No |
| f. Clandestine Drug Labs: | Yes | No |
| g. Dusty Environments: | Yes | No |
| h. Other: _____ | | |

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

3. List your previous occupations: _____

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

5. Other than medications mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes No

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

6. How often are you expected to use the respirator(s) (circle "Yes" or "No" for all answers that apply to you)?:

- | | | |
|--------------------------------|-----|----|
| 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: | Yes | No |

7. During the period you are using the respirator(s), is your work effort:

- a. Light? Yes No

If "yes," how long does this period last during the average shift: _____ hours _____ minutes.

Examples of a *light work* effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.

- b. Moderate: Yes No

If "yes," how long does this period last during the average shift?: _____ hours. _____ minutes.

Examples of *moderate work* effort 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.

c. Heavy

Yes No

If "yes," how long does this period last during the average shift: _____ hrs. _____ minutes.

Examples of *heavy work* are 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.).

8. Will you be working under hot conditions (temperature exceeding 77 deg. F)?: Yes No

9. Will you be working under humid conditions?: Yes No

10. Describe the work you'll be doing while you're using your respirator(s): _____

11. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

Part C. (Full-Facepiece Respirators and SCBAs)

Questions 1 to 6 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.

1. Have you ever lost vision in either eye (temporarily or permanently?): Yes No

2. 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

3. Have you ever had an injury to your ears, including a broken ear drum? Yes No

- | | | |
|--|-----|----|
| 4. 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 |
| 5. Have you ever had a back injury?: | Yes | No |
| 6. 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 respirator: | Yes | No |

CERTIFICATION: I certify that I have provided true and complete information concerning my health.

Employee Signature

Date