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Respirator Medical Evaluation Questionnaire

INSTRUCTIONS: The information in this questionnaire is confidential and will be used to determine your ability to use and wear a tight-fitting respirator in the workplace, so please keep this in mind when answering these questions. Your supervisor must allow you to fill out this questionnaire during normal working hours, at a time and place that is convenient to you. Do not permit anyone to look at or review your answers. **When completed, drop-off or mail the questionnaire to the address below,** and notify City of Boise Risk and Safety Services that you have submitted a *Respirator Medical Evaluation Questionnaire*. If you would like to contact the health care professional who will review your information, please call **St. Luke's Occupational Health 208-706-7500**.

Mail or deliver questionnaire to: **St. Luke's Occupational Health**
703 Americana Blvd, Suite 130
Boise ID 83702

Your Department:	**Your Division:**	**Your Employee ID#:**

SECTION 1 – Please answer all questions

1. **Today's date:**
2. **Your name:** (Last)_____ (First)_____
3. **Your birthday (mo/day/year)**: (____/____/_____) **Your age** (to the nearest year):
4. **Sex** (circle one): MALE / FEMALE
5. **Your height:** _____ ft ____ in
6. **Your weight:** _____ lbs
7. **Your job title:** _____
8. **Phone number where you can be reached by the health care professional who reviews this questionnaire (include area code): (_____) - _____ - _____**
9. **The best time to call you at this number:**
10. **Has your employer told you how to contact the health care professional who will review this questionnaire?** YES / NO
11. **Check the type of respirator you will use** (you can check more than one category):
    a. Disposable Respirator marked ____ N, ____R, or ____ P (Examples: filter-mask, non-cartridge type only), OR
    b. ____ Other type (Examples: half- or full-face-piece type)
12. **Have you worn a respirator before?** YES / NO. If Yes, what type and when?

_____

_____

SECTION 2 - Please answer questions 1-9, and 10-15 if applicable.

1. **Do you *currently* smoke tobacco, or have you smoked tobacco in the last month?** YES / NO

Name:_____ Date: _____

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 spaces): YES / NO
e. Trouble smelling odors: YES / NO

3. Have you *ever had* any of the following lung problems:

YES	NO	PROBLEM	YES	NO	PROBLEM
		Asbestosis			Tuberculosis
		Asthma			Silicosis
		Chronic bronchitis			Pneumothorax (collapsed lung)
		Emphysema			Lung cancer
		Pneumonia			Broken ribs
		Any chest injuries or surgeries?			
		Any other lung problem that you've been told about?			

4. Do you *currently* have any of the following symptoms of pulmonary lung illness:

Symptom	YES	NO
Shortness of breath		
Shortness of breath when walking fast on level ground or walking up a slight hill/incline		
Shortness of breath when walking with other people at an ordinary pace on level ground		
Have to stop for breath when walking at your own pace on level ground		
Shortness of breath when washing or dressing yourself		
Shortness of breath that interferes with your job		
Coughing that produces phlegm (thick sputum)		
Coughing that wakes you early in the morning		
Coughing that occurs mostly when you are lying down		
Coughing up blood in the last month		
Wheezing		
Wheezing that interferes with your job		
Chest pain when you breathe deeply		
Any other symptoms that you think may be related to lung problems		

5. Have you *ever had* any of the following cardiovascular or heart problems:

Problem	YES	NO
Heart problem		
Heart attack		
Stroke		
Angina		
Heart failure		
Swelling in your legs or feet (not caused by walking)		
Heart arrhythmia (heart beating irregularly)		
High blood pressure		
Any other heart problem that you've been told about		

6. Have you *ever had* any of the following cardiovascular or heart symptoms:

Symptom	YES	NO
Frequent pain or tightness in your chest		
Pain or tightness in your chest during physical activity		
Pain or tightness in your chest that interferes with your job		
In the past two years, have you noticed your heart skipping or missing a beat		
Heartburn or indigestion that is not related to eating		
Any other symptoms that you think may be related to heart or circulation problems		

7. Do you *currently* take medication for any of the following problems:

Problem	YES	NO
Breathing or lung problems		
Heart trouble		
Blood pressure		
Seizures		

Name:_____ Date: _____

8. If you've used a respirator, have you *ever had* any of the following problems?

Problem	YES	NO
Eye irritation		
Skin allergies or rashes		
Anxiety		
General weakness or fatigue		
Any other problem that interferes with your use of a respirator		

9. Would you like to talk to the health care professional who will review this questionnaire about your answers? YES / NO

If you are going to wear FULL FACE-PIECE RESPIRATORS or SCBAs, please answer questions 10-15. If not, please skip to Section 3.

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:

Problem	YES	NO
Wear contact lenses		
Wear glasses		
Color blind		
Any other eye or vision problems		

12. Have you *ever had* an injury to your ears, including a broken eardrum? YES / NO

13. Do you *currently* have any of the following hearing problems:

Problem	YES	NO
Difficulty hearing		
Wear a hearing aid		
Any other hearing or ear problem		

14. Have you *ever had* a back injury? YES / NO

15. Do you *currently* have any of the following musculoskeletal problems:

Problem	YES	NO
Weakness in any of your arms, hands, legs, or feet		
Back pain		
Difficulty fully moving your arms and legs		
Pain or stiffness when you lean forward or backward at the waist		
Difficulty fully moving your head up or down		
Difficulty fully moving your head side to side		
Difficulty bending at your knees		
Difficulty squatting to the ground		
Climbing a flight of stairs or ladder carrying more than 25 lbs.		
Any other muscle or skeletal problem that interferes with using a respirator		

SECTION 3 – Please answer all questions

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

If YES, do you *ever have* feelings of dizziness, shortness of breath, pounding in your chest or other symptoms when you are working under these conditions? 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? YES / NO

If YES, name the chemicals if you know them:

_____

_____

Name:_____ Date: _____

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

Material/Condition	YES	NO
Asbestos		
Silica (e.g. in sandblasting)		
Tungsten/cobalt (e.g. grinding or welding on this material)		
Beryllium		
Aluminum		
Coal (for example, mining)		
Iron		
Tin		
Dusty environments		
Any other hazardous exposures		

If YES, please describe these exposures:

_____

_____

_____

4. Please list any second jobs or side businesses you have:

_____

_____

_____

5. Please list your previous occupations:

_____

_____

_____

6. Please list your current and previous hobbies:

_____

_____

_____

7. Have you *ever* been in the military services? YES / NO

If YES, were you exposed to biological or chemical agents, either in training or combat? YES / NO

8. Have you *ever* worked on a HAZMAT team? YES / NO

9. Other than medications for breathing/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)? YES / NO

If YES, name the medications if you know them:

_____

_____

_____

10. Will you be using any of the following items with your respirator(s):

Item	YES	NO
HEPA Filters		
Canisters		
Cartridges		

11. How often are you expected to use the respirator(s) (mark all answers that apply):

Frequency	Yes	No	Frequency	Yes	No
Escape only (no rescue)			Emergency rescue only		
Less than 2 hours per week			Less than 5 hours per week		
2-4 hours per day			Over 4 hours per day		

Name:_____ Date: _____

12. During the period you are using the respirator(s), your work effort is (please circle the letter):

a. **LIGHT** - less than 200 kcal/hour; sitting while writing, typing, drafting, or performing light assembly work, or standing while operating a drill press or controlling machines)
b. **MODERATE** – 200 – 350 kcal/hour; 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 (~35lbs) at truck 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 (~100lbs) on a level surface.
c. **HEAVY** – 350kcal/hour; lifting a heavy load (~50lbs) 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 (~50lbs).

13. Will you be wearing protective clothing and/or equipment (other than respirator) when using your respirator? YES / NO **If YES**, please describe this protective clothing and/or equipment:

_____

_____

_____

14. Will you be working under hot conditions (temperature exceeding 77°F)? YES / NO

15. Will you be working under humid conditions? YES / NO

16. Describe the work you will be doing while you're using your respirator(s):

_____

_____

_____

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s), such as wearing the respirator in a confined space, or in life-threatening gases:

_____

_____

_____

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):

Name of toxic substance	Est. max. exposure level/shift	Duration of exposure/shift

Please list any other toxic substances that you'll be exposed to while using your respirator:

_____

_____

_____

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):

_____

_____

_____