MEDICAL QUESTIONNAIRE FOR RESPIRATOR USERS

Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require medical

To the

This questionnaire will be evaluated by a licensed health care professional in order to determine any health problems that may prevent you from, or restrict you, while wearing a respirator. The intent of these questions is to determine if the difficulty you experience, if any, is medically significant.

To maintain your confidentiality, you 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

Part A. Section 1. The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's 06/06/2014
2. Your phuong nguyen 2
3. Your Age (to nearest 2013
4. Sex (circle ☑ Mal / ☐ Female
5. Your 180
6. Your 90
7. Your job jhs
8. A phone number where you can be reached by the health care professional who questionnaire (include the Area sa
9. The best time to phone you on this 909090
10. Has your employer told you how to contact the health care professional who will questionnaire (circle ☐ Yes / ☑ No
11. Check the type of respirator you will use (you can check more than one
    a. N,R, or P disposable respirator (filter-mask, non-cartridge
    b. Other type (for example, half or full-face piece type, powered-air purifying, self contained breathing
12. Have you worn a respirator (circle ☐ Yes / ☑ No

If yes, what type _____

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Part A. Section 2. 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 ☐ Yes / ☑ No
2. Have you ever has any of the following
   a) Seizures ☐ Yes / ☑ No
   b) Diabetes (sugar ☐ Yes / ☑ No
   c) Allergic reactions that interfere with your ☐ Yes / ☑ No
   d) Claustrophobia (fear of closed in ☐ Yes / ☑ No
   e) Trouble smelling ☐ Yes / ☑ No
3. Have you ever had any of the following pulmonary or lung
   a) ☐ Yes / ☑ No
   b) ☐ Yes / ☑ No
   c) Chronic ☐ Yes / ☑ No
   d) ☐ Yes / ☑ No
   e) ☐ Yes / ☑ No
   f) ☐ Yes / ☑ No
   g) Silicosis: ☐ Yes / ☑ No
   h) Pneumothorax (collapsed ☐ Yes / ☑ No
   i) Lung ☐ Yes / ☑ No
   j) Broken ☐ Yes / ☑ No
   k) Any chest injuries or ☐ Yes / ☑ No
   l) Any other lung problem that you’ve been told ☑ Yes / ☐ No
      XAdasd
4. Do you currently have any of the following symptoms of pulmonary or
   a) Shortness of ☐ Yes / ☑ No
   b) Shortness of breath when walking fast on level ground or walking up a slight hill or impair your ability to wear a ☐ Yes / ☑ No
   c) Shortness of breath when walking with other people at an ordinary pace on level ☐ Yes / ☑ No
   d) Have to stop for breath when walking at your own pace on level ☐ Yes / ☑ No
   e) Shortness of breath when washing or dressing ☐ Yes / ☑ No
   f) Shortness of breath that interferes with ☐ Yes / ☑ No
   g) Coughing that produces phlegm (thick ☐ Yes / ☑ No
   h) Coughing that wakes you early in the ☐ Yes / ☑ No
   i) Coughing that occurs mostly when you are lying ☐ Yes / ☑ No
   j) Coughing up blood in the last ☐ Yes / ☑ No
   k) ☐ Yes / ☑ No
   l) Wheezing that interferes with your ☐ Yes / ☑ No
   m) Chest pain when you breathe ☐ Yes / ☑ No
   n) Any other symptoms that you think may be related to lung ☐ Yes / ☑ No

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5. Have you ever had any of the following cardiovascular or heart
   a) Heart ☐ Yes / ☑ No
   b) Stroke: ☐ Yes / ☑ No
   c) ☐ Yes / ☑ No
   d) Heart ☐ Yes / ☑ No
   e) Swelling in your legs or feet (not caused by ☐ Yes / ☑ No
   f) Heart arrhythmia (heart beating ☐ Yes / ☑ No
   g) High blood ☐ Yes / ☑ No
   h) Any other heart problem that you've been told ☐ Yes / ☑ No

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6. Have you ever had any of the following cardiovascular or heart
   a) Frequent pain or tightness in your ☐ Yes / ☑ No
   b) Pain or tightness in your chest during physical ☐ Yes / ☑ No
   c) Pain or tightness in your chest that interferes with ☐ Yes / ☑ No
   d) In the past two years have you noticed your heart skipping or ☐ Yes / ☑ No
   e) Heartburn or indigestion that is not related to ☐ Yes / ☑ No
   f) Any other symptoms that you think may be related to heart or circulation ☐ Yes / ☑ No

7. Do you currently take medication for any of the following
   a) Breathing or lung ☐ Yes / ☑ No
   b) Heart ☐ Yes / ☑ No
   c) Blood ☐ Yes / ☑ No
   d) Seizures ☐ Yes / ☑ No

8. If you've used a respirator, have you ever had any of the following problem? (if you've never respirator, check the following space and go to

☐ Never used a respirator
   a) Eye ☐ Yes / ☐ No
   b) Skin allergies or ☐ Yes / ☐ No
   c) ☐ Yes / ☐ No
   d) General weakness or ☐ Yes / ☐ No
   e) Any other problem that interferes with your use of a ☐ Yes / ☐ No

9. Would you like to talk to the health care professional who will review this questionnaire about your to this ☐ Yes / ☑ No

MEDICAL QUESTIONNAIRE FOR RESPIRATOR USERS

Questions 10 to 15 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 or respirators, answering those questions is voluntary.

10. Have you every lost vision in either eye (temporarily or ☐ Yes / ☑ No

11. Do you currently have any of the following vision
    a) Wear contact ☐ Yes / ☑ No
    b) Wear ☐ Yes / ☑ No
    c) Colour ☐ Yes / ☑ No
    d) Any other eye or vision ☐ Yes / ☑ No

12. Have you ever had an injury to your ears, including a broken ☐ Yes / ☑ No

13. Do you currently have any of the following hearing ☐ Yes / ☑ No
    a) Difficulty ☐ Yes / ☑ No
    b) Wear a hearing ☐ Yes / ☑ No
    c) Any other hearing or ear ☐ Yes / ☑ No

14. Have you ever had a back ☐ Yes / ☑ No

15. Do you currently have any of the following musculoskeletal
    a) Weakness in any of your arms, hands, legs, or ☐ Yes / ☑ No
    b) Back ☐ Yes / ☑ No
    c) Difficulty fully moving your arms and ☐ Yes / ☑ No
    d) Difficulty fully moving your head up or ☐ Yes / ☑ No
    e) Pain or stiffness when you lean forward or backward at ☐ Yes / ☑ No
    f) Pain or difficulty fully moving your head side ☐ Yes / ☑ No
    g) Difficulty bending at your knees that may impair your ability to wear a ☐ Yes / ☑ No
    h) Difficulty squatting to the ground that may impair your ability to wear a ☐ Yes / ☑ No
    i) Climbing a flight of stairs or a ladder carrying more than 25 lbs. (e.g. SCBA) that may ability to wear a ☐ Yes / ☑ No
    j) Any other muscle or skeletal problem that interferes with using a ☐ Yes / ☑ No

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Request for Medical Clearance for Respirator Use

Employee _____ Date of _____ Departmen _____

Social _____ Supervisor _____

Circle type or types of respirator(s) to be

- ☐ Atmosphere-supplying
- ☐ Open-circuit
- ☐ Supplied-air
- ☐ Air-purifying (non-
- ☐ Continuous-flow
- ☐ Closed-circuit SCBA
- ☐ Combination air-line and
- ☐ Air-purifying (powered)

Level of Work

☐ Ligh ☐ Moderat ☐ Heavy ☐ Strenuou

Extent of

- ☐ 1) On a daily basis
- ☐ 2) Occasionally – but more than once per
- ☐ 3) Rarely – or for emergency situations

Length of Time anticipated Effort in _____

Special Work Considerations (i.e., high places, temperature, hazardous material, protective clothing, etc.)

_____

Safety _____

HEALTH CARE PROFESSIONAL'S EVALUATION OF: _____ (EMPLOYEE)

CLASS (Circle):

- ☐ 1) No restriction on respirator usage
- ☐ 2) Some specific use restrictions
- ☐ 3) No respirator use permitted

Restrictions

_____

_____

Examining Health Care _____ Date: 06/06/2014