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 examination.

To the Employee:

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 review it.

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 date: 23/11/2014
2. Your Name: null test test
3. Your Age (to nearest year): _____
4. Sex (circle one): ☐ Male / ☐ Female
5. Your Height: 11
6. Your Weight: 11
7. Your job title: 11
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): 111111111
9. The best time to phone you on this number: 11
10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): ☐ Yes / ☐ No
11. 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. Other type (for example, half or full-face piece type, powered-air purifying, supplied-air, self contained breathing apparatus). ☐
12. Have you worn a respirator (circle one): ☐ Yes / ☐ No

If yes, what type(s): _____

MEDICAL QUESTIONNAIRE FOR RESPIRATOR USERS

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 last month: ☐ Yes / ☐ No

2. Have you ever has 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 odours: ☐ 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 that may impair your ability to wear a respirator?: ☐ 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
   n) Any other symptoms that you think may be related to lung problems: ☐ Yes / ☐ No

MEDICAL QUESTIONNAIRE FOR RESPIRATOR USERS

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 problem? (if you've never used a respirator, check the following space and go to question

☐ Never used a respirator
   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

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 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) Colour Blind: ☐ Yes / ☐ No
    d) Any other eye or vision problem: ☐ Yes / ☐ No

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

13. 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 problems: ☐ Yes / ☐ No

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

15. 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) Difficulty fully moving your head up or down: ☐ Yes / ☐ No
    e) Pain or stiffness when you lean forward or backward at the waist: ☐ Yes / ☐ No
    f) Pain or difficulty fully moving your head side to side: ☐ Yes / ☐ No
    g) Difficulty bending at your knees that may impair your ability to wear a respirator: ☐ Yes / ☐ No
    h) Difficulty squatting to the ground that may impair your ability to wear a respirator: ☐ Yes / ☐ No
    i) Climbing a flight of stairs or a ladder carrying more than 25 lbs. (e.g. SCBA) that may impair your ability to wear a respirato: ☐ Yes / ☐ No
    j) Any other muscle or skeletal problem that interferes with using a respirator: ☐ Yes / ☐ No

MEDICAL QUESTIONNAIRE FOR RESPIRATOR USERS

Request for Medical Clearance for Respirator Use Questionnaire

Employee: _____ Date of Birth: _____ Department: _____

Social Security: _____ Supervisor: _____

Circle type or types of respirator(s) to be used:

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

Level of Work Effort:

☐ Light ☐ Moderate ☐ Heavy ☐ Strenuous

Extent of Usage:

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

Length of Time anticipated Effort in Hours: _____

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

_____

Safety Representative/Supervisor: _____

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 Professional: _____ Date: 23/11/2014