Spectrum Health Medical Group

EMPLOYEE'S QUESTIONNAIRE FOR OSHA RESPIRATOR MEDICAL EVALUATION - OCCUPATIONAL HEALTH

TO BE COMPLETED BY EMPLOYEE.

EMPLOYEE: Can you read? ☐ NO ☐ YES *(check one)*

Your employer must allow you to answer these questionnaires 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. You will be contacted if a follow-up medical examination is required.

SECTION 1 (Mandatory): The following information must be provided by every employee who has been selected to use ANY TYPE OF RESPIRATOR. *(print clearly)*

1. Company name _____ Date _____
2. Full legal name _____ Date of birth _____
3. Your age (to nearest year) _____
4. Sex: *(check one)* ☐ Male ☐ Female
5. Your height _____ feet _____ inches
6. Your weight _____ pounds
7. Your job title _____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire. Include area code _____
9. The best time to phone you at the above number _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ No ☐ Yes
11. Check the type of respirator you will use: *(you may check more than one category)*
    - ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
    - ☐ Other type (for example, half or full facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you ever wore a respirator? ☐ No ☐ Yes
    If yes, what type(s) _____

SECTION 2: (Questions 1 - 9) MANDATORY FOR USER OF ANY TYPE OF RESPIRATOR

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? ☐ No ☐ Yes
   Do you still smoke? ☐ No ☐ Yes
   If no, when did you quit? _____
   Have you tried to quit smoking? ☐ No ☐ Yes
   How much do you/did you typically smoke per day? _____
   How many years did you smoke/have you smoked? _____
2. HAVE YOU EVER HAD ANY OF THE CONDITIONS BELOW:
   Seizures? ☐ **No** ☐ **Yes**
   When was your: First episode _____ Last episode _____
   What are your seizures like?
   _____
   Do you know what your seizure diagnosis is? _____ ☐ No ☐ Yes
   Do you take any anti-seizure medicine(s)? ☐ No ☐ Yes
   If yes, list medicine(s) _____

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SECTION 2: (Questions 1 - 9) MANDATORY FOR USER OF ANY TYPE OF RESPIRATOR *(CONTINUED)*

2. HAVE YOU EVER HAD ANY OF THE CONDITIONS BELOW: *(Continued)*

Diabetes (sugar disease)? ☐ **No** ☐ **Yes**
When were you diagnosed? _____
Do you use insulin or any other diabetes medicine(s)? ☐ No ☐ Yes
If yes, list medicine(s)
_____
How well controlled is your diabetes? _____
Have you had times when your blood sugar is very low (hypoglycemic)? ☐ No ☐ Yes
If no, do you know what to do when this happens? ☐ No ☐ Yes

Allergic reaction that makes it harder to breath? ☐ **No** ☐ **Yes**
If yes, what are you allergic to? _____
Describe how bad the reactions have been?
_____
Can you control the reaction either with or without medicine? ☐ No ☐ Yes

Claustrophobia (fear of closed-in places)? ☐ **No** ☐ **Yes**
Do you react to having objects on or near your face (compared to feeling closed-in in rooms)? ☐ No ☐ Yes
IF YOU WEAR AN N95 MASK: Do you think you might have difficulty wearing a mask? ☐ No ☐ Yes

Trouble smelling odors? ☐ **No** ☐ **Yes**
Are there specific odors you are not able to smell? ☐ No ☐ Yes
If yes, what are they? _____
Has this problem ever put you in danger (like not smelling smoke)? ☐ No ☐ Yes

3. HAVE YOU EVER HAD ANY OF THE LUNG (PULMONARY) PROBLEMS BELOW?

Asbestosis? ☐ **No** ☐ **Yes**
What were you diagnosed with? _____
When were you diagnosed? _____
What treatments have you had? _____
Do you still have treatments? ☐ No ☐ Yes
If yes, what are they? _____
How does this affect your daily breathing and activity?
_____

Asthma? ☐ **No** ☐ **Yes**
Do specific things "trigger" your asthma (e.g., allergies, exercise, etc.)? ☐ No ☐ Yes
If yes, describe _____
Do you take medicine(s) for asthma? ☐ No ☐ Yes
If yes, how often do you take it/them? _____
How often do you have flare-ups? _____
How bad are your flare-ups? _____
How hard is it for you to control your flare-ups?
_____

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SECTION 2: (Questions 1 - 9) MANDATORY FOR USER OF ANY TYPE OF RESPIRATOR *(CONTINUED)*

3. HAVE YOU EVER HAD ANY OF THE LUNG (PULMONARY) PROBLEMS BELOW? *(Continued)*

Chronic (existing for a long time or often coming back) bronchitis? ☐ **No** ☐ **Yes**
- Is your bronchitis truly a CHRONIC condition (not just once in a while)? ☐ No ☐ Yes
- Does it affect your breathing or activity on daily basis? ☐ No ☐ Yes
- Do you take daily medicine(s) for it? ☐ No ☐ Yes
  - If yes, list medicine(s)

_____

Emphysema? ☐ **No** ☐ **Yes**
- What type were you diagnosed with? _____
- When were you diagnosed? _____
- What treatment(s) have you tried? _____
- Do you have a current treatment? _____
- How does it affect your breathing or activity on daily basis?

_____

Pneumonia? ☐ **No** ☐ **Yes**
- What type were you diagnosed with? _____
- When did you have pneumonia? _____
- What type of treatments/procedures did you have?

_____
- Did you stay in the hospital for your pneumonia? ☐ No ☐ Yes
  - If yes, did you recover completely? ☐ No ☐ Yes

Tuberculosis (TB)? ☐ **No** ☐ **Yes**
- When were you diagnosed? _____
- How was it treated? _____
- Did you finish the treatment? ☐ No ☐ Yes
- Is your TB considered "active" (infectious)? ☐ No ☐ Yes
- Does it affect your breathing? ☐ No ☐ Yes

Silicosis? ☐ **No** ☐ **Yes**
- What type were you diagnosed with? _____
- When were you diagnosed? _____
- What treatment(s) have you tried? _____
- Do you have a current treatment? ☐ No ☐ Yes
- How does it affect you on a daily basis? _____

Collapsed lung (pneumothorax)? ☐ **No** ☐ **Yes**
- What type were you diagnosed with? _____
- When did you have your pneumothorax? _____
- What type of treatments/procedures did you have?

_____
- Did you stay in the hospital for your pneumothorax? ☐ No ☐ Yes
  - If yes, did you recover completely? ☐ No ☐ Yes

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SECTION 2: (Questions 1 - 9) MANDATORY FOR USER OF ANY TYPE OF RESPIRATOR *(CONTINUED)*

3. HAVE YOU EVER HAD ANY OF THE LUNG (PULMONARY) PROBLEMS BELOW? *(Continued)*

Lung cancer? ☐ **No** ☐ **Yes**
What type were you diagnosed with? _____
When were you diagnosed? _____
What treatment(s) have you tried? _____
Do you have a current treatment? ☐ No ☐ Yes
How does it affect you on a daily basis? _____

Broken ribs? ☐ **No** ☐ **Yes**
What type were you diagnosed with? _____
When did you have your broken ribs? _____
What type of treatments/procedures did you have?
_____
Did you stay in the hospital for your broken ribs? ☐ No ☐ Yes
If yes, did you recover completely? ☐ No ☐ Yes

Any injuries to or procedures of your chest area? ☐ **No** ☐ **Yes**
What type were you diagnosed with? _____
When did you have this? _____
What type of treatments/procedures did you have?
_____
Did you stay in the hospital for your injuries/procedures? ☐ No ☐ Yes
If yes, did you recover completely? ☐ No ☐ Yes

Any other lung problem(s) that you've been told you have? ☐ **No** ☐ **Yes**
What type were you diagnosed with? _____
When did you have this? _____
What treatment(s) did you have? _____
How did treatments affect you? _____

4. AT THIS TIME, DO YOU HAVE ANY OF THE SYMPTOMS OF LUNG (PULMONARY) ILLNESS BELOW?

Shortness of breath? ☐ **No** ☐ **Yes**
How often does it happen? _____
When do you have shortness of breath? *(check all that apply)*
☐ Walking fast on level ground or walking up a slight hill/incline.
☐ Walking with other people at an regular pace on level ground.
☐ When washing or dressing yourself.
☐ _____
Do you have to stop for breath when walking at your own pace on level ground? ☐ No ☐ Yes
Describe how bad it is? _____
Does it limit how active you are? ☐ No ☐ Yes
Does it get in the way of doing your job? ☐ No ☐ Yes
Does it require treatment (rather than just resting until it clears)? ☐ No ☐ Yes

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SECTION 2: (Questions 1 - 9) MANDATORY FOR USER OF ANY TYPE OF RESPIRATOR *(CONTINUED)*

4. AT THIS TIME, DO YOU HAVE ANY OF THE SYMPTOMS OF LUNG (PULMONARY) ILLNESS BELOW? *(Continued)*

Coughing? ☐ **No** ☐ **Yes**

How often does it happen? _____

What things do you notice about your coughing? *(check all that apply)*

- ☐ Causes thick spit (phlegm)
- ☐ Awakens you early in the morning
- ☐ Happens mostly when you are lying down

Have you coughed up blood in the last month? ☐ No ☐ Yes

Wheezing? ☐ **No** ☐ **Yes**

How often does it happen? _____

What causes you to do it? _____

Describe how bad it is? _____

Does it limit how active you are? ☐ No ☐ Yes

Does it cause difficulty breathing? ☐ No ☐ Yes

Does it get in the way of doing your job? ☐ No ☐ Yes

Does it require treatment? ☐ No ☐ Yes

Chest pain when you breathe deeply? ☐ **No** ☐ **Yes**

How often does it happen? _____

Describe how bad it is? _____

Any other symptoms that you think may be related to lung problems? ☐ **No** ☐ **Yes**

What symptoms are you experiencing?

_____

When/how often does it happen? _____

Describe how bad it is? _____

_____

Does it require treatment? ☐ No ☐ Yes

5. HAVE YOU EVER HAD ANY OF THE CARDIOVASCULAR/HEART PROBLEMS BELOW?

Heart attack? ☐ **No** ☐ **Yes**

What type were you diagnosed with? _____

When did this/these happen? _____

What are your symptoms? _____

What are your current treatment(s)? _____

Stroke? ☐ **No** ☐ **Yes**

What type were you diagnosed with? _____

When did this/these happen? _____

What are your symptoms? _____

What are your current treatment(s)? _____

Angina? ☐ **No** ☐ **Yes**

What type were you diagnosed with? _____

When did this/these happen? _____

What are your symptoms? _____

What are your current treatment(s)? _____

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SECTION 2: (Questions 1 - 9) MANDATORY FOR USER OF ANY TYPE OF RESPIRATOR *(CONTINUED)*

5. HAVE YOU EVER HAD ANY OF THE CARDIOVASCULAR/HEART PROBLEMS BELOW? *(Continued)*

Heart failure? ☐ **No** ☐ **Yes**
What type were you diagnosed with? _____
When did this/these happen? _____
What are your symptoms? _____
What are your current treatment(s)? _____

Swelling in your legs or feet (not caused by walking)? ☐ **No** ☐ **Yes**
What type were you diagnosed with? _____
When did this/these happen? _____
What are your symptoms? _____
What are your current treatment(s)? _____

Heart arrhythmia (heart beating irregularly)? ☐ **No** ☐ **Yes**
What type were you diagnosed with? _____
When did this/these happen? _____
What are your symptoms? _____
What are your current treatment(s)? _____

High blood pressure? ☐ **No** ☐ **Yes**
How long have you had high blood pressure? _____
Is it controlled at this time? _____
Do you take medicine(s) for high blood pressure? ☐ No ☐ Yes
If yes: List medicine(s) _____
List any side effects _____
Has your high blood pressure caused negative effects (like kidney or circulation problems)? ☐ No ☐ Yes
If yes, what are they? _____

Any other heart problem that you've been told you have? ☐ **No** ☐ **Yes**
What type were you diagnosed with? _____
When did this/these happen? _____
What are your symptoms? _____
What are your current treatment(s)? _____

6. HAVE YOU EVER HAD ANY OF THE CARDIOVASCULAR/HEART SYMPTOMS BELOW?

Pain or tightness in your chest that happens often? ☐ **No** ☐ **Yes**
How long have you had this? _____
When/how does it happen? _____
What other symptoms do you have with this? _____
Have you seen a doctor about this? ☐ No ☐ Yes

Pain or tightness in your chest during physical activity? ☐ **No** ☐ **Yes**
How long have you had this? _____
When/how does it happen? _____
What other symptoms do you have with this? _____
Have you seen a doctor about this? ☐ No ☐ Yes

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SECTION 2: (Questions 1 - 9) MANDATORY FOR USER OF ANY TYPE OF RESPIRATOR *(CONTINUED)*

6. HAVE YOU EVER HAD ANY OF THE CARDIOVASCULAR/HEART SYMPTOMS BELOW? *(Continued)*

Pain or tightness in your chest that gets in the way of doing your job? ☐ **No** ☐ **Yes**
- How long have you had this? _____
- When/how does it happen? _____
- What other symptoms do you have with this? _____
- Have you seen a doctor about this? ☐ No ☐ Yes

In the past two years, have you noticed your heart skipping/missing a beat? ☐ **No** ☐ **Yes**
- Does it happen at certain times (versus randomly)? ☐ No ☐ Yes
- How long does it usually last? _____
- Are you able to continue normal activities when it happens? ☐ No ☐ Yes
- Do you have other symptoms (e.g., dizziness, shortness of breath, etc.)? ☐ No ☐ Yes
  - If yes, describe _____

Heartburn/indigestion that is NOT related to eating? ☐ **No** ☐ **Yes**
- Have you seen a doctor about this? ☐ No ☐ Yes
  - If yes, what did the doctor say about it?

  _____
- Do/does heartburn medicine(s) help with the problem? ☐ No ☐ Yes

Any other symptoms that you think may be related to heart or blood circulation problems? ☐ **No** ☐ **Yes**
- What symptoms do you have? _____
- When/how often do you have symptoms? _____
- How bad are you symptoms? _____
- Do these symptoms need to be treated? ☐ No ☐ Yes

7. AT THIS TIME, DO YOU TAKE MEDICINE(S) FOR ANY OF THE PROBLEMS BELOW?

Breathing or lung problems? ☐ **No** ☐ **Yes**
- List medicine(s) you take for it _____
- Do medicines control the problem? ☐ No ☐ Yes
- Do you have side effects from the medicines? ☐ No ☐ Yes
  - If yes, describe _____

Heart trouble? ☐ **No** ☐ **Yes**
- List medicine(s) you take for it _____
- Do medicines control the problem? ☐ No ☐ Yes
- Do you have side effects from the medicines? ☐ No ☐ Yes
  - If yes, describe _____

Blood pressure? ☐ **No** ☐ **Yes**
- List medicine(s) you take for it _____
- Do medicines control the problem? ☐ No ☐ Yes
- Do you have side effects from the medicines? ☐ No ☐ Yes
  - If yes, describe _____

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SECTION 2: (Questions 1 - 9) MANDATORY FOR USER OF ANY TYPE OF RESPIRATOR *(CONTINUED)*

7. AT THIS TIME, DO YOU TAKE MEDICINE(S) FOR ANY OF THE PROBLEMS BELOW? *(Continued)*

Seizures? ☐ **No** ☐ **Yes**
List medicine(s) you take for it _____
Do medicines control the problem? ☐ No ☐ Yes
Do you have side effects from the medicines? ☐ No ☐ Yes
If yes, describe _____

8. HAVE YOU EVER USED A RESPIRATOR? ☐ **No** ☐ **Yes**
IF YES, HAVE YOU EVER HAD ANY OF THE PROBLEMS BELOW?

Eye irritation? ☐ **No** ☐ **Yes**
Describe the problem _____
Describe how bad it is/was _____
How often did it happen? _____
What type of respirator is/was it? _____

Skin allergies/rashes? ☐ **No** ☐ **Yes**
Describe the problem _____
Describe how bad it is/was _____
How often did it happen? _____
What type of respirator is/was it? _____

Anxiety? ☐ **No** ☐ **Yes**
Describe the problem _____
Describe how bad it is/was _____
How often did it happen? _____
What type of respirator is/was it? _____

General weakness or fatigue? ☐ **No** ☐ **Yes**
Describe the problem _____
Describe how bad it is/was _____
How often did it happen? _____
What type of respirator is/was it? _____

Any other problems that interferes with your use of a respirator? ☐ **No** ☐ **Yes**
Describe the problem _____
Describe how bad it is/was _____
How often did it happen? _____
What type of respirator is/was it? _____

Using an N95 respirator? ☐ **No** ☐ **Yes**
Describe the problem _____
Describe how bad it is/was _____
How often did it happen? _____
What type of respirator is/was it? _____

9. Would you like to talk to the health care professional who will review this questionnaire and/or your answers? ☐ No ☐ Yes

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SECTION 3: (Questions 10 - 15)

Have you been selected to use either a full-facepiece respirator or a self contained breathing apparatus (SCBA)? ☐ **No** ☐ **Yes**

If no, continue to next question.

If yes, it is <u>MANDATORY</u> you complete Section 3.

Have you been selected to use other types of respirators? ☐ **No** ☐ **Yes**

If no or yes, it is <u>YOUR CHOICE (OPTIONAL)</u> to complete Section 3.

If you choose not to complete Section 3, skip to the signature area below.

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

11. At this time, do you have any of the eye/vision problems below? ☐ No ☐ Yes

    If yes, check all that apply:

    ☐ Wear contact lenses ☐ Color blind ☐ Wear glasses

    ☐ Other eye/vision problem _____

12. Have you ever had an injury to your ears (including a broken ear drum)? ☐ No ☐ Yes

13. Do you currently have any ear/hearing problems below? ☐ No ☐ Yes

    If yes, check all that apply:

    ☐ Difficulty hearing ☐ Wear a hearing aid

    ☐ Other ear/hearing problem _____

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

15. Your musculoskeletal system includes your bones, cartilage, ligaments, tendons and connective tissues. At this time, do you have any muscule or skeletal (musculoskeletal) problems? ☐ No ☐ Yes

    If yes, check all that apply:

    ☐ 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 a ladder carrying more than 25 pounds

    ☐ Other muscle or skeletal problem that would get in the way of using a respirator _____

I certify that my answers are complete and accurate to the best of my knowledge.

Date _____ Employee signature _____

Submit by Email to: Onsite@spectrumhealth.org

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