



Medical Questionnaire for Respirator Users

Instructions

Part A. Please fill out this questionnaire related to your former, current, or anticipated use of a respirator. When completed, please email completed form to OHD@montclair.edu, or deliver to Occupational Health (Blanton Hall) Room 1201 or send via interoffice mail to OHD. **Note: Please do not forget to sign and date the last page. 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. **Today's date:** ___/___/___
2. **Your name:** _____
3. **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. **A phone number where you can be reached by the health care professional who reviews this questionnaire:** (____) - _____
9. **The best time to phone you at this number:** _____
10. **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 (e.g., half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
11. **Have you worn a respirator (circle one): Yes/No**
 - a. If yes, what type: _____



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 check “yes” or “no”).

	Yes	No
1. Do you <i>currently</i> smoke tobacco, or have you smoked tobacco in the last month?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you <i>ever had</i> any of the following conditions?		
a. Seizures	<input type="checkbox"/>	<input type="checkbox"/>
b. Diabetes (sugar disease)	<input type="checkbox"/>	<input type="checkbox"/>
c. Allergic reactions that interfere with your breathing	<input type="checkbox"/>	<input type="checkbox"/>
d. Claustrophobia (fear of closed-in places)	<input type="checkbox"/>	<input type="checkbox"/>
e. Trouble smelling odors	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you <i>ever had</i> any of the following pulmonary or lung problems?		
a. Asbestosis	<input type="checkbox"/>	<input type="checkbox"/>
b. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
c. Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
d. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
e. Silicosis	<input type="checkbox"/>	<input type="checkbox"/>
f. Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/>
g. Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>
h. Broken ribs	<input type="checkbox"/>	<input type="checkbox"/>
i. Any chest injuries or surgeries	<input type="checkbox"/>	<input type="checkbox"/>
j. Any other lung problem that you’ve been told about	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you <i>currently</i> have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	<input type="checkbox"/>	<input type="checkbox"/>
c. Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
d. Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
e. Shortness of breath when washing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>
f. Shortness of breath that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
g. Coughing that produces phlegm (thick sputum)	<input type="checkbox"/>	<input type="checkbox"/>
h. Coughing that wakes you early in the morning	<input type="checkbox"/>	<input type="checkbox"/>



i. Coughing that occurs mostly when you are lying down

Yes No

j. Coughing up blood in the last month

k. Wheezing

l. Wheezing that interferes with your job

m. Chest pain when you breathe deeply

n. 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?

a. Heart attack

b. Stroke

c. Angina

d. Heart failure

e. Swelling in legs or feet (not caused by walking)

f. Heart arrhythmia (heart beating irregularly)

g. High blood pressure

h. Any other heart problem that you've been told about

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

a. Frequent pain or tightness in your chest

b. Pain or tightness in your chest during physical activity

c. Pain or tightness in your chest that interferes with your job

d. In the past two years, have you noticed your heart skipping or missing a beat?

e. Heartburn or indigestion that is not related to eating

f. Any other symptoms you that you think may be related to heart or circulation problems

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

a. Breathing or lung problems

b. Heart trouble

c. Blood pressure

d. Seizures

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

(If you've never used a respirator, check the following space and go to question 9):

a. Eye irritation

b. Skin allergies or rashes

c. Anxiety



- d. General weakness or fatigue
- e. 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 to this questionnaire?** Yes No
-

Questions 10 to 15 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.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 10. Have you <i>ever</i> lost vision in either eye (temporarily or permanently)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you <i>currently</i> have any of the following vision problems? | | |
| a. Wear contact lenses | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Wear glasses | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Color blind | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Any other eye or vision problem | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you <i>ever had</i> an injury to your ears, including a broken eardrum? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you <i>currently</i> have any of the following hearing problems? | | |
| a. Difficulty hearing | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Wear a hearing aid | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Any other hearing or ear problem | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you <i>ever</i> had a back injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you <i>currently</i> have any of the following musculoskeletal problems? | | |
| a. Weakness in any of your arms, hands, legs, or feet | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Back pain | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Difficulty fully moving your arms and legs | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Pain and stiffness when you lean forward or backward at the waist | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Difficulty moving your head up or down | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Difficulty moving your head side to side | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Difficulty bending at your knees | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Difficulty squatting to the ground | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs. | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Any other muscle or skeletal problem that interferes | <input type="checkbox"/> | <input type="checkbox"/> |



Part B, Section 1 (To be completed at your appointment)

Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. **In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen?**

Yes No

If yes, do you 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 or hazardous airborne chemicals (for example: gasses, fumes, or solvents)?**

Yes No

If yes, name the chemicals if you know them:

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

	Yes	No
a. Asbestos	<input type="checkbox"/>	<input type="checkbox"/>
b. Silica (for example: sandblasting)	<input type="checkbox"/>	<input type="checkbox"/>
c. Tungsten/cobalt (for example: grinding or welding this material)	<input type="checkbox"/>	<input type="checkbox"/>
d. Beryllium	<input type="checkbox"/>	<input type="checkbox"/>
e. Aluminum	<input type="checkbox"/>	<input type="checkbox"/>
f. Coal (for example: mining)	<input type="checkbox"/>	<input type="checkbox"/>
g. Iron	<input type="checkbox"/>	<input type="checkbox"/>
h. Tin	<input type="checkbox"/>	<input type="checkbox"/>
i. Dusty environments	<input type="checkbox"/>	<input type="checkbox"/>
j. Any other hazardous exposures	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of the above, describe these exposures:

4. **List any second jobs or side businesses you have:**



5. List your previous occupations:

6. List your current and previous hobbies:

7. Have you 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 and 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:

	Yes	No
a. HEPA filters	<input type="checkbox"/>	<input type="checkbox"/>
b. Canisters (for example: gas masks)	<input type="checkbox"/>	<input type="checkbox"/>
c. Cartridges	<input type="checkbox"/>	<input type="checkbox"/>

11. How often are you expected to use the respirator(s)?

- Escape only (no rescue)
- Emergency rescue only
- Less than 5 hours per week



- Less than 2 hours per day
- 2 to 4 hours per day
- Over 4 hours per day

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

a. Light (less than 200 kcal per hour)

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

Yes No

If yes, how long does this period last during the average shift: ____ hrs ____ mins

b. Moderate (200 to 350 kcal per hour)

Examples of moderate work 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 at 5 – degree grade about 3 mph, or pushing a wheelbarrow with a heavy load (about 100 lbs) on a level surface

Yes No

If yes, how long does this period last during the average shift: ____ hrs ____ mins

c. Heavy (above 350 kcal per hour)

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)

Yes No

If yes, how long does this period last during the average shift: ____ hrs ____ mins

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator?

Yes No

If yes, describe this protective clothing and/or equipment:

14. Will you be working under hot conditions (temperature exceeding 77 deg. F)?

Yes No

15. Will you be working under humid conditions?

Yes No

16. Describe the work you'll 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) (for example, confined spaces, 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 first toxic substance: _____

Estimated maximum exposure per shift: _____

Duration of exposure per shift: _____

Name of second toxic substance: _____

Estimated maximum exposure per shift: _____

Duration of exposure per shift: _____

Name of third toxic substance: _____

Estimated maximum exposure per shift: _____

Duration of exposure per shift: _____

Name of any other toxic substances that you'll be exposed to while using your respirator(s):

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):

I, _____, certify that the above information is accurate and complete to the best of my knowledge.

Signature

Date

This medical questionnaire was reviewed by _____ on _____.

This person

IS medically cleared to be fit tested for the specified respirator

IS NOT medically cleared to be fit tested for the specified respirator