Confidential Medical Questionnaire

OSHA requires that the following information be provided by every employee who has been selected to use any type of respirator. Your employer must allow you to answer this questionnaire 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.

Can you read? ☐ YES ☐ NO

OSHA 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. Has your employer told you how to contact the health care professional who will review this questionnaire?
   ☐ YES ☐ NO
2. Have you ever worn a Respirator? ☐ YES ☐ NO
   If YES what type(s) _____

Date	Name	☐ MALE ☐ FEMALE	SSN (Last 5)
Agency Crafton Hills College	Location/Dept. Anatomy & Physiology		Phone #
Height ft. in.	Weight lbs.	Birthdate	Age / Best Time to Contact

Check type of respirator you will use (*Check all that apply*)

☒ N, R, or P Disposable Respirator (*Filter-Mask, Non-Cartridge type only*) **N95 Respirator**	☐ Self-Contained Breathing Apparatus (SCBA)
☐ Negative pressure Air Purifying Respirator (APR)	☐ Supplied Air
☐ Powered Air Purifying Respirator (PAPR)	☐ Other

OSHA 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 answer YES or NO to every answer

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

2. Have you ***ever had*** any of the following conditions?

Seizures	☐ YES	☐ NO
Claustrophobia	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Trouble Smelling Odors	☐ YES	☐ NO
Allergic Reactions that interfere with breathing	☐ YES	☐ NO

3. Have you ***ever had*** any of the following pulmonary or lung problems?

Asbestosis	☐ YES	☐ NO	Pneumonia	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO	Tuberculosis	☐ YES	☐ NO
Silicosis	☐ YES	☐ NO	Broken Ribs	☐ YES	☐ NO
Lung Cancer	☐ YES	☐ NO	Chronic bronchitis	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Any chest injuries or surgeries	☐ YES	☐ NO
Any other lung problems	☐ YES	☐ NO	Pneumothorax (Collapsed Lungs)	☐ YES	☐ NO

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

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

5. Do you ***currently*** have any of the following symptoms of cardiovascular or heart problems?

Heart Attack	☐ YES	☐ NO
Angina	☐ YES	☐ NO
Heart Failure	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Swelling in your legs or feet (not caused by walking)	☐ YES	☐ NO
Heart arrythmia (irregular heart beat)	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
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?

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

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

Breathing or lung problems	☐ YES	☐ NO
Blood pressure	☐ YES	☐ NO
Heart trouble	☐ YES	☐ NO
Seizures (Fits)	☐ YES	☐ NO

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

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

9. Would you like to talk to the healthcare professional who will review this questionnaire? ☐ YES ☐ NO

Questions 10-15 must be answered by employees who have been selected to use either a ***full face respirator or Self Contained Breathing Apparatus (SCBA)***
For employees who will not wear a full face respirator or SCBA, these questions are voluntary.

10. Have you ***ever*** lost vision in either eye (permanently or temporary)? ☐ YES ☐ NO

11. Do you ***currently*** have any of the following vision problems?

Wear contact lenses	☐ YES	☐ NO
Wear glasses	☐ YES	☐ NO
Color blind	☐ YES	☐ NO
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?

Difficulty hearing	☐ YES	☐ NO
Wear hearing aids	☐ YES	☐ NO
Any other ear or hearing problem	☐ YES	☐ NO

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

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

Weakness in any of your arms, hands, legs, or feat	☐ YES	☐ NO
Back pain	☐ YES	☐ NO
Difficulty moving or arms or legs	☐ YES	☐ NO
Pain or stiffness when bending forward or backward at your waist	☐ YES	☐ NO
Difficulty fully moving your head up and down	☐ YES	☐ NO
Difficulty fulling moving your head side to side	☐ YES	☐ NO
Difficulty bending at your knees	☐ YES	☐ NO
Difficulty squatting to the ground	☐ YES	☐ NO
Climbing a flight of stairs or ladder carrying more than 25lbs of weight	☐ YES	☐ NO
Any other muscle or skeletal problem that you've been told about	☐ YES	☐ NO

OSHA Part B: Any of the following questions, and other questions not listed, may be added at the discretion of the health care professional who will review the medical 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're 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

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

Substance/Conditions			Descriptions of exposures
Asbestos	☐ YES	☐ NO	
Silica (e.g. in sandblasting)	☐ YES	☐ NO	
Cobalt (Grinding or Welding)	☐ YES	☐ NO	
Beryllium	☐ YES	☐ NO	
Aluminum	☐ YES	☐ NO	
Coal (Mining)	☐ YES	☐ NO	
Iron	☐ YES	☐ NO	
Tin	☐ YES	☐ NO	
Dusty Environments	☐ YES	☐ NO	
Any other exposures	☐ YES	☐ NO	

4. List any second jobs or side business you have:

5. List your previous occupations:

6. List your current hobbies and previous hobbies:

7. Have you ever been in the military? ☐ YES ☐ NO

   If "yes", were you exposed to biological or chemical agents 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(s)? *(Completed by OCMO)*
    a. HEPA Filters ☐ YES ☒ NO
    b. Canisters (for example, gas masks) ☐ YES ☒ NO
    c. Cartridges ☐ YES ☒ NO

11. How often are you expected to use the respirator(s)? Check all that apply
    ☐ Escape only (no rescue)
    ☐ Less than 5 hours per week
    ☒ Less than 2 hours per day
    ☐ 2 to 4 hours per day
    ☐ Over 4 hours per day
    ☐ Emergency rescue only

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

Light (less than 200kcal/hour) ☐ YES ☐ NO	If "yes" how long does this period last during the average shift ____ Hours ____ Minutes
Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs) or controlling machines	

Moderate (200 to 350 kcal/hour) ☐ YES ☐ NO	If "yes" how long does this period last during the average shift ____ Hours ____ Minutes
Examples of moderate work effort 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 (35 lbs) at trunk 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 (100 lbs) on a level surface.	

Heavy (above 350 kcal/hour) ☒ YES ☐ NO	If "yes" how long does this period last during the average shift 2 Hours ____ Minutes
Examples of heavy work effort are lifting a heavy load (50 lbs) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or shipping castings; walking up an 8 degree grade about 2 mph; climbing stairs with a heavy load (50 lbs).	

13. Will you be wearing protective clothing and/or equipment when using your respirator ☒ YES ☐ NO

If " yes" describe this protective clothing and/or equipment

Safety glass or face shield; gloves;gown or jumpsuit; hearing protection;xray vest; shoe covering; Safety vest

14. Will you be working under cold or hot conditions ☒ YES ☐ NO

☒ <0˚ F ☒ 0˚ - 32˚ F ☒ 77˚ - 90˚ F ☒ >90˚ F

15. Will you be working under dry or humid conditions (<30% RH or >70% RH)? ☒ YES ☐ NO

16. Describe the work you'll be doing while wearing your respirator(s):

Prehospital and hospital based pt. care; moving patients and equipment;

17. Describe any special hazardous conditions you might encounter when you're using your respirator(s) Examples include: Confined Spaces or Life-Threatening Gases, IDLH

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when using your respirator(s)

Name of Toxic Substance	Estimated Max Exposure per Shift	Duration of Exposure per Shift

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well being of others (Examples include: rescue or security)

By signing below I affirm that the information listed above is true and accurate to the best of my knowledge.

Employee Signature Date

When completed please printout this form, sign it, and bring it and the Medical Clearance Form the Fit Test Site.

Print Form