

Medical Questionnaire for Respiratory Protective Equipment

Iowa State University Occupational Medicine Program

G11 Technical and Administrative Services Facility (TASF) / 2408 Pammel Drive, (515) 294-2056

To the employee:

You must be allowed to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, only the ISU Occupational Medicine health care professionals may review your answers. Your supervisor must tell you how to deliver or send this questionnaire to the ISU Occupational Medicine physician who will review it.

Section 1. The following information must be provided by every employee who is required to use any type of respirator (please print).

Part A. Personal information

1. Today's date: _____
2. Your name: _____

Last	First	MI
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3. ISU ID #: _____
4. Birthdate: _____
5. Job title: _____
6. Supervisor: _____
7. Department: _____
8. Work phone number: _____
9. Sex (check one): Male Female
10. Your height: _____ ft. _____ in.
11. Your weight: _____ lbs.
12. Has your employer told you how to contact the health care professional who will review this questionnaire? (check one): Yes No
13. Check the type of respirator you will use (you can check more than one category)
 - dust mask
 - full-face
 - half-face
 - power air purifying respirator (PAPR)
 - self-contained breathing apparatus (SCBA)
14. Have you ever used a respirator? Yes No
 If "yes," what type(s): _____

Part B. Respirator use information

1. How often (frequency) and for how long (duration) will you use your respirator? _____

2. What type of activities will be performed while you wear your respirator? _____

3. List any additional personal protective equipment (e.g., Tyvek suit, gloves, winter clothing, etc.) worn during respirator use. _____

4. What are the temperature and humidity extremes (highest & lowest) that may be encountered on your job?

Section 2. Questions 1 through 9 below must be answered by every employee who is required to use any type of respirator (please check "yes" or "no").

- | | <u>Yes</u> | <u>No</u> |
|---|--------------------------|--------------------------|
| 1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had any of the following conditions? | | |
| a) Seizures (fits) | <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 ever had 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) Emphysema | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Silicosis | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Pneumothorax (collapsed lung) | <input type="checkbox"/> | <input type="checkbox"/> |
| i) Lung cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| j) Broken ribs | <input type="checkbox"/> | <input type="checkbox"/> |
| k) Any chest injuries or surgeries | <input type="checkbox"/> | <input type="checkbox"/> |
| l) Any other lung problem that you've been told about | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you currently 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 | <input type="checkbox"/> | <input type="checkbox"/> |
| j) Coughing up blood in the last month | <input type="checkbox"/> | <input type="checkbox"/> |
| k) Wheezing | <input type="checkbox"/> | <input type="checkbox"/> |
| l) Wheezing that interferes with your job | <input type="checkbox"/> | <input type="checkbox"/> |
| m) Chest pain when you breathe deeply | <input type="checkbox"/> | <input type="checkbox"/> |
| n) Any other symptoms that you think may be related to lung problems | <input type="checkbox"/> | <input type="checkbox"/> |

- | | <u>Yes</u> | <u>No</u> |
|---|--------------------------|--------------------------|
| 5. Have you ever had any of the following cardiovascular or heart problems? | | |
| a) Heart attack | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Angina | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Heart failure | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Swelling in your legs or feet (not caused by walking) | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Heart arrhythmia (heart beating irregularly) | <input type="checkbox"/> | <input type="checkbox"/> |
| g) High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Any other heart problem that you've been told about | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had any of the following cardiovascular or heart symptoms? | | |
| a) Frequent pain or tightness in your chest | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Pain or tightness in your chest during physical activity | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Pain or tightness in your chest that interferes with your job | <input type="checkbox"/> | <input type="checkbox"/> |
| d) In the past two years, have you noticed your heart skipping or missing a beat | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Heartburn or indigestion that is not related to eating | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Any other symptoms that you think may be related to heart or circulation problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you currently take medication for any of the following problems? | | |
| a) Breathing or lung problem(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Heart trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Seizures (fits) | <input type="checkbox"/> | <input type="checkbox"/> |
| 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.) | <input type="checkbox"/> | <input type="checkbox"/> |
| a) Eye irritation | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Skin allergies or rashes | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| d) General weakness or fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Any other problem that interferes with your use of a respirator | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Would you like to talk to the health care professional, who will review this questionnaire, about your answers? | <input type="checkbox"/> | <input type="checkbox"/> |

Questions 10 to 15 below must be answered by every employee who is required to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA).

For employees who are required to use other types of respirators, answering these questions is voluntary.

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|---|--------------------------|--------------------------|
| 10. Have you ever lost vision in either eye (temporarily or permanently)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you currently 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 ever had an injury to your ears, including a broken ear drum? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you currently 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 ever had a back injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you currently 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 or stiffness when you lean forward or backward at the waist | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Difficulty fully moving your head up or down | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Difficulty fully 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) 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 with using a respirator | <input type="checkbox"/> | <input type="checkbox"/> |

Signature _____ Date _____

Yes No