Medical Questionnaire for Respirator Users

THE UNIVERSITY OF TEXAS
MD Anderson ~~Cancer~~ Center

Making Cancer History®

Date: ______________________________

Employee: __________________________________ Job Title: ___________________

Emp ID # or SSN: ______________ Dept/Unit: ________ Work Phone #: ________________

Age: _______________________ Height: ______________ Weight: ______________

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).

Have you worn a respirator before? Yes No

If "yes," what type: ____

Questions 1 through 8 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 had** 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 odors: 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. Pheumothorax (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 problems that you've been told about: Yes No

This form contains confidential health information and should be sent directly to: Employee Health & Well-being, Unit 631

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: Yes No
   b. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes No
   c. Have to stop for breath when walking at your own pace on level ground: Yes No
   d. Shortness of breath when washing or dressing yourself: Yes No
   e. Shortness of breath that interferes with your job: Yes No
   f. Coughing that produces phlegm (thick sputum): Yes No
   g. Coughing that wakes you early in the morning: Yes No
   h. Coughing that occurs mostly when you are lying down: Yes No
   i. Coughing up blood in the last month: Yes No
   j. Wheezing: Yes No
   k. Wheezing that interferes with your job: Yes No
   l. Chest pain when you breathe deeply: Yes No
   m. Any other symptoms that you think may be related to heart or circulation problems: Yes No

5. Have you **ever had** any of the following cardiovascular of 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 problems? (If you've never used a respirator, check the following space and go to question 9:) _____
   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

Questions 9 to 14 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 of respirators, answering these questions in voluntary.

9. Have you **ever lost** vision in either eye (temporarily or permanently): Yes No

10. Do you **currently** have any of the following vision problems?
    a. Wear contact lenses: Yes No
    b. Wear glasses: Yes No
    c. Color blind: Yes No
    d. Any other eye or vision problem: Yes No

11. Have you **ever had** an injury to your ears, including a broken ear drum: Yes No

12. Do you **currently** have any of the following hearing problems?
    a. Difficulty hearing: Yes No
    b. Wear a hearing aid: Yes No
    c. Any other hearing or ear problem: Yes No

13. Have you **ever had** a back injury? Yes No

14. 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. Pain or stiffness when you learn forward or backward at the waist: Yes No
    e. Difficulty fully moving your head up or down: Yes No
    f. Difficulty fully moving your head side to side: Yes No
    g. Difficulty bending at your knees: Yes No
    h. Difficulty squatting to the ground: Yes No
    i. Climbing a flight of stairs or a ladder carrying more that 25 lbs: Yes No
    j. Any other muscle or skeletal problem that interferes with using a respirator: Yes No

______________________________ Employee Signature

______________________________ Health Care Provider Signature

______________________________ Date

______________________________ Date

Reference: Appendix C to CFR1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory).

FOR OFFICE USE ONLY

Cleared for N95 respirator use? *Circle one:* YES NO

Cleared for full face or SCBA? *Circle one:* YES NO N/A