**Appendix C1: Medical Questionnaire**



**To the employee:** You are being provided time to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your supervisor must not look at or review your answers, and your supervisor or HR must tell you how to deliver or send this questionnaire to the health care professional who will review it. **Please fill out this questionnaire as accurately as possible.**

**Part A, Section 1 (Mandatory):**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Employee/Student:** | | |  | | | | | | **Job Title:** | |  | | | | |
| **Supervisor:** | | | |  | | | | | **Date:** | |  | | | | |
| **Age:** | |  | | | | **Sex (M/F):** | |  | **Height**  **(\_\_ft \_\_in):** |  | | | **Weight (lbs):** | |  |
| **Phone # where Health Care Professional can reach you:** | | | | | | |  | | **Best time to phone you at this number:** | | | | |  | |
| **Has your employer told you how to contact the health care professional (if not your own HCP) who will review this questionnaire (circle one): Yes / No** | | | | | | | | | | | | | | | |
| **Check the type of respirator you will use (you can check more than one category:**   1. **\_\_\_ N, R, or P disposable respirator (filter mask, non-cartridge type only).** 2. **\_\_X\_ Other type (e.g., half- or full-facepiece type; powered air purifying)** | | | | | | | | | | | | | | | |
| **Respirator Make:** | 3M | | | | **Respirator Model:** | | | 3M 6100 Half Facepiece with 3M 6005 Organic Vapor cartridges | | | | **Respirator Size:** | | TBD | |
| **Have you worn a respirator previously (circle one): Yes / No**  **If yes, what type(s):** | | | | | | | | | | | | | | | |

**Type of Exposure(s)**

**Potentially harmful substance(s):**

**The duration and frequency of respirator use:**

|  |  |
| --- | --- |
| Less than 5 hours *per week* | **Yes / No** |
| Less than 2 hours *per day* | **Yes / No** |
| 2 to 4 hours *per day* | **Yes / No** |
| Over 4 hours *per day* | **Yes / No** |

**The expected physical work effort:**

|  |  |
| --- | --- |
| Light (e.g., *sitting* while typing or performing light assembly work; *standing* while operating a drill press or controlling machines) | **Yes / No** |
| Moderate (e.g., 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 a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface) | **Yes / No** |
| Heavy (e.g., 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** |

**Additional protective equipment to be worn:**

**Temperature and humidity extremes that may be encountered:** None

**Appendix C1: Medical Questionnaire**



**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 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?**

|  |  |
| --- | --- |
| Seizures | **Yes / No** |
| Diabetes (sugar disease) | **Yes / No** |
| Allergic reactions that interfere with your breathing | **Yes / No** |
| Claustrophobia (fear of closed-in places) | **Yes / No** |
| Trouble smelling odors | **Yes / No** |

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

|  |  |
| --- | --- |
| Asbestosis | **Yes / No** |
| Asthma | **Yes / No** |
| Chronic bronchitis | **Yes / No** |
| Emphysema | **Yes / No** |
| Pneumonia | **Yes / No** |
| Tuberculosis | **Yes / No** |
| Silicosis | **Yes / No** |
| Pneumothorax (collapsed lung) | **Yes / No** |
| Lung cancer | **Yes / No** |
| Broken ribs | **Yes / No** |
| Any chest injuries or surgeries | **Yes / No** |
| Any other lung problem that you've been told about | **Yes / No** |

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

|  |  |
| --- | --- |
| Shortness of breath | **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 when washing or dressing yourself | **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 mostly when you are lying down | **Yes / No** |
| Coughing up blood in the last month | **Yes / No** |
| Wheezing | **Yes / No** |
| Wheezing that interferes with your job | **Yes / No** |
| Chest pain when you breathe deeply | **Yes / No** |
| Any other symptoms that you think may be related to lung problems | **Yes / No** |

**Appendix C1: Medical Questionnaire**



**Part A, Section 2 (Mandatory).**

1. **Have you ever had any of the following cardiovascular or heart problems?**

|  |  |
| --- | --- |
| Heart attack | **Yes / No** |
| Stroke | **Yes / No** |
| Angina | **Yes / No** |
| Heart failure | **Yes / No** |
| Heart arrhythmia (heart beating irregularly) | **Yes / No** |
| Swelling in your legs or feet (not caused by walking) | **Yes / No** |
| High blood pressure | **Yes / No** |
| Any other heart problem that you've been told about | **Yes / No** |

1. **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** |

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

|  |  |
| --- | --- |
| Breathing or lung problems | **Yes / No** |
| Heart trouble | **Yes / No** |
| Blood pressure | **Yes / No** |
| Seizures | **Yes / No** |

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

|  |  |
| --- | --- |
| If you've never used a respirator, circle “No” and go to question 9 | **No** |
| Eye irritation | **Yes / No** |
| Skin allergies or rashes | **Yes / No** |
| Anxiety | **Yes / No** |
| General weakness or fatigue | **Yes / No** |
| Any other problem that interferes with your use of a respirator | **Yes / No** |

1. **Would you like to talk to the health care professional who will review this   
   questionnaire about your answers to this questionnaire? Yes / No**

**Employee Comments:**

Employee/Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appendix C1: Medical Questionnaire**



**Part B (Optional Questions).**

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. **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:

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

|  |  |
| --- | --- |
| Asbestos | **Yes / No** |
| Silica (e.g., in sandblasting) | **Yes / No** |
| Tungsten/cobalt (e.g., grinding or welding this material) | **Yes / No** |
| Beryllium | **Yes / No** |
| Aluminum | **Yes / No** |
| Coal | **Yes / No** |
| Iron | **Yes / No** |
| Tin | **Yes / No** |
| Dusty environments | **Yes / No** |
| Any other hazardous exposures | **Yes / No** |

If "yes," please describe these exposures:

1. **List any second jobs or side businesses you have:**
2. **List your previous occupations:**
3. **List your current and previous hobbies:**
4. **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

1. **Have you ever worked on a HAZMAT team? Yes / No**
2. **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**

Employee/Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_