WASHINGTON HEALTH SYSTEM
Occupational Medicine

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Combined Respirator / General Medical Questionnaire

Can you read? ☐ **Yes** ☐ **No**

Today's Date	**Your Name**	**Date of Birth:**	**Your age (to nearest year)**
Your Sex ☐ **Male** ☐ **Female**	**Your height** _____ ft. _____ in.	**Your weight** _____ lbs.	**Your job title**
Phone number (include area code):		**Best time to phone you at this number:**	

☐ **Yes** ☐ **No** **Has your employer told you how to contact the health care professional who will review this questionnaire?**

☐ **Yes** ☐ **No** **Would you like to talk to the reviewing health care professional about your answers to this questionnaire?**

Medication – please list both past and present medications

Medication Name	**Dose, frequency**	**Current or Past**	**Any side effects to this medication**

YES	NO	**Are you CURRENTLY taking medication for any of the following problems?**
☐	☐	Breathing or lung problems
☐	☐	Heart trouble
☐	☐	Blood pressure
☐	☐	Seizures (fits/convulsions / Epilepsy)

Please list any Medication Allergies, Intolerances, Adverse Reactions:

Surgical History – Please list your surgeries, their dates, any ongoing issues, & any **current** medical restrictions your surgeon has placed upon you.

_____
_____
_____
_____
_____
_____
_____
_____

Hospitalizations – Please list any **Hospital Admissions**, dates, why you were there**:**

Social History

	YES	NO	
Do you drink alcohol?	☐	☐	If so, frequency and amount:
Smoke (now or in the past)?	☐	☐	If so, frequency and amount:
Take habit forming drugs?	☐	☐	If yes, what are they:
Treated for drug addiction?	☐	☐	If yes, when did you complete treatment?
Treated for alcoholism?	☐	☐	If yes, when did you complete treatment?

YES	NO	
☐	☐	16. Do you currently have any work **restrictions**? If yes, what are they? _____

Past Occupational History

Please list your **prior jobs** in Reverse Chronology:

Job Title	Employer	Dates of Employment

YES	NO	Don't Know	Immunization (Shots) History
☐	☐	☐	Are your vaccinations up to date?

Respirator Questions:

Check the type of respirator(s) you will use:

☐ N, R, or P disposable respirator (filter-mask, non- cartridge type only).

☐ Other type (e.g., half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

YES	NO	Past Respirator Use:
☐	☐	Have you ever worn a respirator? If yes, what type(s): _____

Have you **ever had** any of the following problems with respirator use?

☐ If you have never used a respirator, please check the box & go to the "Spirometry Screening" section below.

☐	☐	Eye irritation?
☐	☐	Skin allergies or rashes?
☐	☐	Anxiety?
☐	☐	General weakness or fatigue?
☐	☐	Any other problem that interferes with your use of a respirator? If yes, please describe problem(s): _____

YES	NO	Spirometry Screening:
☐	☐	Do you currently smoke regularly? - If yes, how many years have you smoked cigarettes? ☐ < 1 year ☐ >1 year
☐	☐	***Have you smoked within the past hour?***
☐	☐	If you do not currently smoke, did you smoke in the past? - If yes, how many years did you smoke cigarettes? ☐ < 1 year ☐ >1 year - How many years ago did you quit? ☐ < 1 year ☐ >1 year

YES	NO	**Spirometry Screening** *(continued)*:
		What is the greatest number of packs per day that you have smoked? _____ - How many packs a day do you smoke now? _____
☐	☐	***Have you eaten a large meal within the last hour?***
☐	☐	***Do you currently have an acute illness?***
☐	☐	***In the past 3 weeks, have you had a respiratory illness or ear infection?***
☐	☐	***In the past 2 months, have you undergone LASIK eye surgery?***
☐	☐	***In the past 3 months, have you undergone any type of surgery other than LASIK?***
☐	☐	***In the past 3 months, have you suffered a stroke or heart attack?***
☐	☐	***Do you use inhaled medications?*** - If yes, what are their names? _____ - When were they last used? _____
☐	☐	***Any current history of untreated pneumothorax (collapsed lung)?***
☐	☐	***Any unstable heart, vascular conditions?***
☐	☐	***Any history of thoracic, abdominal, or cerebral aneurysm?***
☐	☐	***Any other current disease that may interfere with test performance?***

OSHA & General Medical History Questions:

YES	NO	Do you have any of the following symptoms?	Explanation	Current Issue	Past Issue
☐	☐	Shortness of breath			
☐	☐	Shortness of breath when walking fast on level ground or walking up a slight hill or incline			
☐	☐	Shortness of breath when walking with other people at an ordinary pace on level ground			
☐	☐	Have to stop for breath when walking at your own pace on level ground			
☐	☐	Shortness of breath when washing or dressing yourself			
☐	☐	Shortness of breath that interferes with your job			
☐	☐	Coughing that produces phlegm (thick sputum)			
☐	☐	Coughing that wakes you early in the morning			
☐	☐	Coughing that occurs mostly when you are lying down			
☐	☐	Coughing up blood in the last month			
☐	☐	Wheezing			
☐	☐	Wheezing that interferes with your job			
☐	☐	Chest pain when you breathe deeply			
☐	☐	Any other symptoms that you think may be related to lung problems			
☐	☐	Frequent pain or tightness in your chest			
☐	☐	Pain or tightness in your chest during physical activity			
☐	☐	Pain or tightness in your chest that interferes with your job			
☐	☐	In the past two years, have you noticed your heart skipping or missing a beat			
☐	☐	Heartburn or indigestion **NOT** related to eating			
☐	☐	Any other symptoms that you think may be related to heart or circulation problems			
YES	**NO**	**General OSHA respirator questions:**	**Explanation**	**Current Issue**	**Past Issue**
☐	☐	Have you **ever lost** vision in either eye (temporarily or permanently)			
☐	☐	Do you wear contact lenses			

YES	NO	**General OSHA respirator questions** *(continued)*:	**Explanation**	**Current Issue**	**Past Issue**
☐	☐	Do you wear glasses			
☐	☐	Have you ever been or are you currently color blind			
☐	☐	Any other eye or vision problem			
☐	☐	Any ear injuries including a broken ear drum			
☐	☐	Any difficulty hearing			
☐	☐	Do you wear a hearing aid			
☐	☐	Any other hearing or ear problem			
☐	☐	Ever had a back or neck injury			
☐	☐	Any Weakness in any of your arms, hands, legs, or feet			
☐	☐	Back pain			
☐	☐	Difficulty fully moving your arms and legs			
☐	☐	Pain or stiffness when you lean forward or backward at the waist			
☐	☐	Difficulty fully moving your head up or down			
☐	☐	Difficulty fully moving your head side to side			
☐	☐	Difficulty bending at your knees			
☐	☐	Difficulty squatting to the ground			
☐	☐	Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs			
☐	☐	Any other muscle or skeletal problem that interferes with using a respirator			
YES	**NO**	**Have you ever had any of the following conditions?**	**Explanation**	**Current Issue**	**Past Issue**
☐	☐	Seizures (fits, convulsions) / Epilepsy			
☐	☐	Trouble smelling odors			
☐	☐	Claustrophobia (fear of closed-in places)			
☐	☐	Diabetes - If yes, how do you treat it? ☐Diet alone ☐Diet plus oral medicine ☐Diet plus insulin (injection)			
☐	☐	Allergic reactions that interfere with your breathing			
☐	☐	Any allergies in general			
☐	☐	Asthma			
☐	☐	Bronchitis: Acute or Chronic			
☐	☐	Pneumonia			
☐	☐	Emphysema			
☐	☐	Tuberculosis			
☐	☐	Asbestosis			
☐	☐	Silicosis			
☐	☐	Pneumothorax (collapsed lung)			
☐	☐	Lung Cancer			
☐	☐	Broken Ribs			
☐	☐	Chest Injuries			
☐	☐	Chest Surgeries			
☐	☐	Any other lung problem that you've been told about			
☐	☐	Stroke			
☐	☐	Numbness / Tingling			

YES	NO	Have you ever had any of the following conditions *(continued)*?	Explanation	Current Issue	Past Issue
☐	☐	Coma / Loss of Consciousness			
☐	☐	Paralysis			
☐	☐	Vertigo / Fainting / Dizziness			
☐	☐	Nervous / Psychological Condition			
☐	☐	Heart Failure			
☐	☐	Heart Attack			
☐	☐	Angina			
☐	☐	Heart Arrhythmia (heart beating irregularly)			
☐	☐	High Blood Pressure			
☐	☐	Any other heart problem that you've been told about			
☐	☐	Swelling in your legs or feet (not caused by walking)			
☐	☐	Skin problems			
☐	☐	LATEX allergy			
☐	☐	Amputations			
☐	☐	Arthritis / Joint problems / injuries			
☐	☐	Broken / Fractured bones			
☐	☐	Stomach Problems			
☐	☐	Kidney / Bladder problems			
☐	☐	Hernias			
☐	☐	Other:			

YES	NO	Past	Current	Part B OSHA respirator questions
☐	☐			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**?
				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
☐	☐			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?
				If "yes," name the chemicals if you know them:
YES	**NO**			Have you ever worked with any of the materials, or under any of the conditions, listed below? (check "yes" or "no" for all answers that apply to you)?
☐	☐			Asbestos
☐	☐			Silica (*e.g.*, in sandblasting)
☐	☐			Tungsten/cobalt (e.g., grinding or welding this material)
☐	☐			Beryllium
☐	☐			Aluminum
☐	☐			Coal (for example, mining)
☐	☐			Iron
☐	☐			Tin
☐	☐			Dusty environments
☐	☐			Any other hazardous exposures
				If "yes," describe these exposures:

List any second jobs or side businesses you have currently:
List your current and previous hobbies:

YES	NO	**Part B OSHA respirator questions** *(continued)*
☐	☐	Have you ever worked on a HAZMAT team?
☐	☐	Have you been in the military services?
		If "yes," were you exposed to biological or chemical agents (either in training or combat)? ☐ Yes ☐ No
YES	**NO**	Will you be using any of the following items with your respirator(s) (check "yes" or "no" for all answers that apply to you)?
☐	☐	HEPA filters
☐	☐	Canisters (for example, gas masks)
☐	☐	Cartridges
YES	**NO**	How often are you expected to use the respirator(s) (check "yes" or "no" for all answers that apply to you)?
☐	☐	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:

YES	NO	During the period you are using the respirator(s), is your **work effort**:
☐	☐	***Light*** **(less than 200 kcal per hour)**
		If "yes," how long does this period last during the average shift: _____hrs._____mins.
		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 per hour)**
		If "yes," how long does this period last during the average shift: _____hrs._____mins.
		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 (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.
☐	☐	***Heavy*** **(above 350 kcal per hour)**
		If "yes," how long does this period last during the average shift: _____hrs._____mins.
		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.).
☐	☐	Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator?
		If "yes," describe this protective clothing and/or equipment:
☐	☐	Will you be working under hot conditions (temperature exceeding 77 deg. F)
☐	☐	Will you be working under humid conditions

Describe the work you'll be doing while you're using your respirator(s):

Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

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):

1. 1st toxic substance name: _____
   Estimated maximum exposure level per shift:_____
   Duration of exposure per shift: _____

2. 2nd toxic substance name: _____
   Estimated maximum exposure level per shift:_____
   Duration of exposure per shift: _____

3. 3rd toxic substance name: _____
   Estimated maximum exposure level per shift:_____
   Duration of exposure per shift: _____

The name of any other toxic substances that you'll be exposed to while using your respirator:
_____
_____
_____

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 information I have provided on the above medical history pages is complete, true, and accurate to the best of my knowledge. I understand that falsification or omission of any of the preceding information would misinform the medical practitioner of my medical history and potentially result in harm to myself, for which I would not hold the medical practitioner responsible. Additionally, the care and information you received today is not a substitute for the care and information that you receive from your primary care physician. I agree that the Health Examination requested by my company is made with my consent and that the examination, test(s), and/or result(s) may be released to the above-named company and/or its representatives.

_____ _____ _____
Patient Signature Printed Date/Time

_____ _____ _____
Reviewer's Signature Printed Date/Time

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