VANTAGE physicians

WISHA Respirator Medical Questionnaire

Part 1 - Employee Background Information

Please print

1. Today's date: _____

2. Your name: _____

3. Your age (to nearest year): _____

4. Sex (circle one): Male / Female

5. Your height: ft. in. _____

6. Your weight: lbs. _____

7. Your job title: _____

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include Area Code): _____

9. The best time to call you at this number: _____

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

11. Check the type of respirator(s) you will be using:

a. N, R, or P filtering-facepiece respirator (for example, a dust mask, OR an N95 filtering-facepiece respirator).

b. Check all that apply.

- Half mask • Full face piece mask • Helmet hood • Escape
- Non-powered cartridge or canister • Powered air-purifying cartridge respirator (PAPR)
- Supplied-air or Air-line
- Self contained breathing apparatus (SCBA): • Demand • Pressure demand

Other: _____

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12. Have you previously worn a respirator? Yes / No

If "yes," describe what type(s): _____

_____

Part 2 - General Health Information

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 places): 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. Pneumothorax (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 problem that you have been told about: Yes / No

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
c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes / No
d. Have to stop for breath when walking at your own pace on level ground: Yes / No
e. Shortness of breath when washing or dressing yourself: Yes / No
f. Shortness of breath that interferes with your job: Yes / No
g. Coughing that produces phlegm (thick sputum): Yes / No
h. Coughing that wakes you early in the morning: Yes / No
i. Coughing that occurs mostly when you are lying down: Yes / No
j. Coughing up blood in the last month: Yes / No

k. Wheezing:	Yes	/	No
l. Wheezing that interferes with your job:	Yes	/	No
m. Chest pain when you breathe deeply:	Yes	/	No
n. Any other symptoms that you think may be related to lung problems:	Yes	/	No
5. Have you *ever had* any of the following cardiovascular or heart problems?	Yes	/	No
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 have 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 2 years, have you noticed your heart skipping:	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?	Yes	/	No
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 have used a respirator, have you *ever had* any of the following problems? (If you have 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
9. Would you like to talk to the health care professional who will review this questionnaire about your answers?	Yes	/	No

Part 3 - Additional Questions for Users of Full-Facepiece Respirators or SCBAs

Please circle "Yes" or "No"

1. Have you *ever lost* vision in either eye (temporarily or permanently)?	Yes	/	No
2. Do you *currently* have any of these vision problems?			
a. Need to wear contact lenses:	Yes	/	No
b. Need to wear glasses:	Yes	/	No
c. Color blindness:	Yes	/	No
d. Any other eye or vision problem:	Yes	/	No
3. Have you *ever had* an injury to your ears, including a broken ear drum?	Yes	/	No
4. Do you *currently* have any of these hearing problems?			
a. Difficulty hearing:	Yes	/	No
b. Need to wear a hearing aid:	Yes	/	No
c. Any other hearing or ear problem:	Yes	/	No
5. Have you *ever had* a back injury?	Yes	/	No
6. 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 lean 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 than 25 lbs:	Yes	/	No
j. Any other muscle or bone injury that interferes with using a respirator?	Yes	/	No

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Part 4 - Discretionary Questions

1. Have you ever been exposed (at work or home) to hazardous solvents, hazardous airborne chemicals (such as 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: _____

_____

_____

_____

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

a. Asbestos?	Yes	/	No
b. Silica (for example, in sandblasting)?	Yes	/	No
c. Tungsten/cobalt (for example, grinding or welding this material)?	Yes	/	No
d. Beryllium?	Yes	/	No
e. Aluminum?	Yes	/	No
f. Coal (for example, mining)?	Yes	/	No
g. Iron?	Yes	/	No
h. Tin?	Yes	/	No
i. Dusty environments?	Yes	/	No
j. Any other hazardous exposures?	Yes	/	No

If "yes," describe these exposures: _____

_____

3. 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

4. Have you ever worked on a HAZMAT team? Yes / No

5. 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: _____

_____

4. Has a Supervisor Reviewed and Signed Your Medical Approval Form?
(If not, please have this completed prior to your medical evaluation.) Yes / No

END

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