

**Mount Sinai-Irving J. Selikoff Center for Occupational & Environmental Medicine
Respirator Medical Evaluation Questionnaire**

To the employee: Can you read (check one): Yes No

If a translator is required, what language: _____

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator. Please print.

Today's date: _____ Interviewer: _____

1. Your name: _____ Last 4 digits of your SS # _____

2. Your Age (to nearest year): _____ Date of Birth: _____

3. Street Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

4. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the area code): (_____) _____
The best time to phone you at this number: _____

5. Ethnicity (optional - circle one): (1) White (Non-Hispanic), (2) African American,
(3) Hispanic, (4) Native American, (5) Other _____

6. Sex (check one): Male Female

7. Your Height: _____ ft. _____ in. 8. Your Weight: _____ lbs.

9. Your Job Title: _____ 10. Union: _____

11. Employer: _____ 12. Work Site: _____

13. Has your employer told you how to contact the health care professional who will review this questionnaire (check one): Yes No

14. 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 (for example, _____ Half or _____ Full-facepiece type, _____ Powered air purifying, _____ Supplied air, _____ Self-contained breathing apparatus)

15. Have you worn a respirator: Yes No

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

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 check "yes" or "no").

1.
 - a. Have you ever smoked tobacco? (If no continue to question 2) Yes No
If **yes**, at what age did you begin? _____
 - b. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month? Yes No
If **no**, how long ago did you quit? _____ Age at that time: _____
Average number of cigarettes per day when you did smoke: _____
 - c. Present average number of cigarettes per day: _____

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
 - f. History of facial burns, serious skin problems on your face, or other facial deformities? Yes No
 - g. Other conditions that may interfere with respirator use or result in limited work ability: 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. History of sinusitis or severe rhinitis (colds): Yes No
 - m. Any other lung problem that you've 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 may be related to lung problems: Yes No
5. Have you *ever had* any of the following cardiovascular or 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
- Are you taking any other medications, including over-the-counter? Yes No
- If yes, please list _____
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
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes No

Questions 10 to 17 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

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

11. 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

12. Have you *ever had* an injury to your ears, including a broken eardrum: Yes No

13. 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

14. Have you *ever had* a back injury: Yes No

15. 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 skeletal problem that interferes with using a respirator: Yes No

16. Have you ever had a chest x-ray? Yes No

If yes, what is the date of your last chest x-ray? _____

To the best of you knowledge, were any abnormalities found? Yes No

If yes, please describe: _____

17. Have you ever had a breathing test? Yes No

If yes, what is the date of your last test? _____

To the best of you knowledge, were any abnormalities found? Yes No

If yes, please describe: _____

Part B: 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. Describe the work you'll be doing while you're using your respirator:

2. Will you be using any of the following items with your respirator?

- a. HEPA Filters (pink, red): Yes No
- b. Canisters (for example, gas masks): Yes No
- c. Cartridges: Yes No

3. How often are you expected to use the respirator (check "yes" or "no" for all answers that apply to you)?:

- a. Escape only (no rescue): Yes No
- b. Emergency rescue only: Yes No
- c. Less than 5 hours *per week*: Yes No
- d. Less than 2 hours *per day*: Yes No
- e. 2 to 4 hours *per day*: Yes No
- f. Over 4 hours *per day*: Yes No

4. During the period you are using the respirator, is your work effort:

a. *Light*: [e.g., sitting while typing or writing; performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.]

- Yes No

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

b. *Moderate*: [e.g., sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, or assembling a moderate load (about 35 lbs.) at trunk level; walking; pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.]

- Yes No

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

c. *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

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

5. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes No

If "yes," describe this protective clothing and/or equipment: _____

6. Describe any special or hazardous conditions you might encounter when you're using your respirator (e.g., confined spaces, life-threatening gases):

7. List the hazardous substances that you work with while wearing a respirator: _____

8. Describe any special responsibilities you'll have while using your respirator that may affect the safety and well-being of others (e.g. rescue, security):

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

- | | | | |
|-----------------------------------|--|--------------------------------------|--|
| a. Asbestos: | <input type="checkbox"/> Yes <input type="checkbox"/> No | b. Silica (e.g., in sandblasting): | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Beryllium: | <input type="checkbox"/> Yes <input type="checkbox"/> No | d. Tungsten/cobalt: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Aluminum: | <input type="checkbox"/> Yes <input type="checkbox"/> No | f. Coal (for example, mining): | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Iron: | <input type="checkbox"/> Yes <input type="checkbox"/> No | h. Dusty environments: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. Tin: | <input type="checkbox"/> Yes <input type="checkbox"/> No | j. Solvents (e.g., paints, lacquers) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| k. Any other hazardous exposures: | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

If "yes," describe these exposures: _____

10. At home have you been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or had skin contact with hazardous chemicals: Yes No

If "yes," name the chemicals if you know them: _____

11. List any second jobs or side businesses you have: _____

12. 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

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