

COUNTY OF ALAMEDA
RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

To the employee: Can you read? Yes No Don't Know

Your employer must allow you to answer the 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. The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's Date: _____
2. Your Name: _____ Maiden Name: _____
Kaiser medical record number: _____ or SS#: XXX-XX-_____
(Last 4 digits)
3. Your Age _____
4. Gender: Male Female
5. Your Height: _____ feet _____ inches Your Weight: _____ lbs.
6. Your Agency/Department & Job Title: _____
7. A phone number where you can be reached by the health care professional who reviews this questionnaire (include area code): _____
8. The best time to reach you at this number: _____
9. Has your employer told you how to contact the health care professional who will review this questionnaire? Yes No Don't Know
10. 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. SCBA respirator (self contained, breathing apparatus)
 - c. Other type (half or full-face type, powered-air purifying, supplied-air)
11. Have you worn a respirator? Yes No Don't Know
If "yes," what type(s): _____

Part A. Section 2. 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 Don't Know
2. Have you ever had any of the following conditions?
a. Seizures (fits): Yes No Don't Know
b. Diabetes (sugar disease): Yes No Don't Know
c. Allergic reactions that interfere with your breathing:
 Yes No Don't Know
d. Claustrophobia (fear of closed-in places): Yes No Don't Know
e. Trouble smelling odors: Yes No Don't Know
3. Have you ever had any of the following pulmonary or lung problems?
a. Asbestosis: Yes No Don't Know
b. Asthma: Yes No Don't Know
c. Chronic bronchitis: Yes No Don't Know
d. Emphysema: Yes No Don't Know
e. Pneumonia: Yes No Don't Know
f. Tuberculosis: Yes No Don't Know
g. Silicosis: Yes No Don't Know
h. Pneumothorax (collapsed lung): Yes No Don't Know
i. Lung cancer: Yes No Don't Know
j. Broken ribs: Yes No Don't Know
k. Any chest injuries or surgeries: Yes No Don't Know
l. Any other lung problem that you've been told about:
 Yes No Don't Know
4. Do you currently have any of the following symptoms of pulmonary or lung illness?
a. Shortness of breath: Yes No Don't Know
b. Shortness of breath when walking fast on level ground or walking up a slight hill or
incline: Yes No Don't Know

- c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes No Don't Know
- d. Have to stop for breath when walking at your own pace on level ground: Yes No Don't Know
- e. Shortness of breath when washing or dressing yourself: Yes No Don't Know
- f. Shortness of breath that interferes with your job: Yes No Don't Know
- g. Coughing that produces phlegm (thick sputum): Yes No Don't Know
- h. Coughing that wakes you early in the morning: Yes No Don't Know
- i. Coughing that occurs mostly when you are lying down: Yes No Don't Know
- j. Coughing up blood in the last month: Yes No Don't Know
- k. Wheezing: Yes No Don't Know
- l. Wheezing that interferes with your job: Yes No Don't Know
- m. Chest pain when you breathe deeply: Yes No Don't Know
- n. Any other symptoms that you think may be related to lung problems: Yes No Don't Know
5. Have you ever had any of the following cardiovascular or heart problems?
- a. Heart attack: Yes No Don't Know
- b. Stroke: Yes No Don't Know
- c. Angina: Yes No Don't Know
- d. Heart failure: Yes No Don't Know
- e. Swelling in your legs or feet (not caused by walking): Yes No Don't Know
- f. Heart arrhythmia (heart beating irregularly): Yes No Don't Know
- g. High blood pressure: Yes No Don't Know
- h. Any other heart problem that you've been told about: Yes No Don't Know
6. Have you ever had any of the following cardiovascular or heart symptoms?
- a. Frequent pain or tightness in your chest: Yes No Don't Know

b. Pain or tightness in your chest during physical activity:
 Yes No Don't Know

c. Pain or tightness in your chest that interferes with your job:
 Yes No Don't Know

d. In the past two years, have you noticed your heart skipping or missing a beat?
 Yes No Don't Know

e. Heartburn or indigestion that is not related to eating:
 Yes No Don't Know

f. Any other symptoms that you think may be related to heart or circulation problems:
 Yes No Don't Know

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

a. Breathing or lung problems: Yes No Don't Know

b. Heart trouble: Yes No Don't Know

c. Blood pressure: Yes No Don't Know

d. Seizures (fits): Yes No Don't Know

8. If you used a respirator, have you ever had any of the following problems?

(If you've never used a respirator, check here and go to question 9)

a. Eye irritation: Yes No Don't Know

b. Skin allergies or rashes: Yes No Don't Know

c. Anxiety: Yes No Don't Know

d. General weakness or fatigue:

e. Any other problem that interferes with your use of a respirator:
 Yes No Don't Know

9. How often are you expected to use the respirator(s)? (Check all that apply)

a. Escape only (no rescue): Yes No Don't Know

b. Emergency rescue only: Yes No Don't Know

c. Less than 5 hours per week: Yes No Don't Know

d. Less than 2 hours per day: Yes No Don't Know

e. 2 to 4 hours per day: Yes No Don't Know

f. Over 4 hours per day: Yes No Don't Know

10. Work requiring respirator use is (check one): Light Moderate Heavy

Examples:

Light: Sitting while writing, performing light assembly work, and controlling machines.

Moderate: Standing while nailing, transferring a 35 lbs object at waist level, and walking on a level surface at 2 mph.

Heavy: Lifting 50 lbs from the floor to your waist, shoveling, and standing while bricklaying.

11. Do you normally have a beard, goatee, mustache, or other facial hair growth?

Yes No Don't Know

If so, does your facial hair come in contact with the seal of the respirator?

Yes No Don't Know

12. How much exercise (outside of work) do you get in typical week? Please explain:

13. Would you like to talk to the health care professional who will review this questionnaire?

Yes No

Questions 14 to 19 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.

14. Have you ever lost vision in either eye (temporarily or permanently)? Yes No

15. 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

16. Have you ever had an injury to your ears, including a broken ear drum? Yes No

17. 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

18. Have you ever had a back injury? Yes No

19. 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 and 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

Signature: _____ Date: _____

Reviewed by: _____ Date: _____