

HSU EH&S Respiratory Protection Form

Name and HSU Employee ID #:

SECTION C – Confidential Medical Questionnaire

Cal/OSHA requires that the following information be provided by every employee who has been selected to use any type of respirator. Your supervisor 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 in this section. **Please take your completed questionnaire (Section C – total of 4 pages) in a sealed envelope labeled with your name AND HSU Employee ID # to Mad River Occupational Health for review by a licensed medical health professional.** Questions regarding the questionnaire or your health and respirator use - call EH&S at Ext 5711.

* Can you read? YES NO

Height: _____ ft. _____ in.	Weight: _____ lbs.	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate: _____
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- Has your employer told you how to contact the health care professional who will review this questionnaire?
 YES NO
- Have you worn a respirator?
 YES NO If “yes,” what type(s):
- If you’ve used a respirator, have you ever had any of the following problems? Check all that apply:
 None Eye irritation Skin allergies or rashes Anxiety
 General weakness or fatigue Any other problem that interferes with your use of a respirator
- Do you currently smoke tobacco, or have you smoked tobacco in the last month?
 YES NO
- Have you ever had any of the following conditions? Check all that apply: None
 Seizures (fits) Diabetes (sugar disease) Allergic reactions that interfere with your breathing
 Trouble smelling odors
 Claustrophobia (fear of closed-in places)
- Have you ever had any of the following pulmonary or lung problems? Check all that apply: None
 Asbestosis Asthma Chronic bronchitis
 Emphysema Pneumonia Tuberculosis
 Silicosis Pneumothorax (collapsed lung)
 Lung cancer Broken ribs Any chest injuries or surgeries
 Any other lung problem that you’ve been told about

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7. Do you currently have any of the following symptoms of pulmonary or lung illness?

Check all that apply:

- None 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

8. Have you ever had any of the following cardiovascular or heart problems? Check all that apply:

- None Heart attack Stroke Angina Heart failure
- Swelling in your legs or feet (not caused by walking)
- Heart arrhythmia (heart beating irregularly) High blood pressure
- Any other heart problem that you've been told about

9. Have you ever had any of the following cardiovascular or heart symptoms? Check all that apply:

- None 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 that is not related to eating
- Any other symptoms that you think may be related to heart or circulation problems

10. Do you currently take medication for any of the following problems? Check all that apply:

- None Breathing or lung problems Heart trouble Blood pressure
- Seizures (fits)

11. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

- YES NO

12. 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 medication(s) if you know them:

13. 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?

- YES NO

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

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

- | | |
|---|--|
| <input type="checkbox"/> Escape only (no rescue) | <input type="checkbox"/> 2 to 4 hours per day |
| <input type="checkbox"/> Less than 5 hours per week | <input type="checkbox"/> Over 4 hours per day |
| <input type="checkbox"/> Less than 2 hours per day | <input type="checkbox"/> Emergency rescue only |

15. During the period you are using the respirator(s), is your work effort:

- Light (less than 200 kcal per hour): 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.

YES NO

If "yes," how long does this period last during the average shift: _____ hours _____ minutes

- Moderate (200 to 350 kcal per hour): 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.

YES NO

If "yes," how long does this period last during the average shift: _____ hours _____ minutes

- Heavy (above 350 kcal per hours): 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.)

YES NO

If "yes," how long does this period last during the average shift: _____ hours _____ minutes

16. 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:

17. Will you be working under hot conditions (temperature exceeding 77°F)?

YES NO

18. Will you be working under humid conditions?

YES NO

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

20. At work or at home, have you ever worked around the following? Please check all hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or hazardous chemicals that you have come into any contact with:

- | | | |
|--|---|---|
| <input type="checkbox"/> Solvents | <input type="checkbox"/> Gases | <input type="checkbox"/> Farming, animal dusts, agr. products |
| <input type="checkbox"/> Mining | <input type="checkbox"/> Grinding | <input type="checkbox"/> Welding |
| <input type="checkbox"/> Asbestos | <input type="checkbox"/> Beryllium | <input type="checkbox"/> Arsenic |
| <input type="checkbox"/> Aluminum | <input type="checkbox"/> Coal dust | <input type="checkbox"/> Mushroom farms |
| <input type="checkbox"/> Flour of any grain | <input type="checkbox"/> Refinish furniture | <input type="checkbox"/> Refurbish automobiles |
| <input type="checkbox"/> Chromium | <input type="checkbox"/> Nickel | <input type="checkbox"/> Tars, tar products |
| <input type="checkbox"/> Lead shot or leaded glass | <input type="checkbox"/> Silica, glass, ceramics, pottery | <input type="checkbox"/> Chemical or biological agents |

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Questions 21 to 26 below must be answered by every employee who has been selected to use either a full-face piece 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.

21. Have you ever lost vision in either eye (temporarily or permanently)?
 YES NO
22. Do you currently have any of the following vision problems?
 YES NO If "yes," check all that apply.
 Wear contact lenses Wear glasses
 Color blind Any other eye or vision problem
23. Have you ever had an injury to your ears including a broken eardrum?
 YES NO
24. Do you currently have any of the following hearing problems? Check all that apply.
 None Wear a hearing aid
 Difficulty hearing Any other hearing or ear problem
25. Have you ever had a back injury?
 YES NO
26. Do you currently have any of the following musculoskeletal problems? Check all that apply.
 None 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 ladder while carrying more than 25 lbs
 Any other muscle or skeletal problem that interferes with using a respirator

By my signature below I affirm that the information listed above is true and accurate to the best of my knowledge.

Employee Signature

Today's Date

PLEASE MAKE SURE TO PUT YOUR NAME AND HSU EMPLOYEE ID # ON ALL PAGES AND ON THE SEALED ENVELOPE MARKED "CONFIDENTIAL" CONTAINING THE COMPLETED MEDICAL QUESTIONNAIRE, SECTION C