Hazardous Materials/Respirator Questionnaire

Minnesota Occupational Health

INTEGRATED, COMPREHENSIVE OCCUPATIONAL HEALTH SERVICES

Patient name:_____ **Date of birth:**_____ / _____ / _____
Month Day Year

Today's date:_____ / _____ / _____ **Company:**_____
Month Day Year

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination. However, certain responses, or patterns of response, may lead the reviewer to request further information, or a medical examination, in order to reach a conclusion regarding the employee's ability to safely use a respirator.

To the employee, Patient ID: _____ 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.

Can you read? ☐ Yes ☐ No

Part A. Section 1. (Mandatory)

Every employee who has been selected to use any type of respirator must provide the following information.

1. Today's date: _____ / _____ / _____
   Month Day Year
2. Your name:_____
3. Your age (to nearest year): _____
4. Sex: ☐ 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 the area code):
   (_____) _____ - _____
9. The best time to call you at this number: _____ a.m./p.m.
10. Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No
11. Check box(es) of the type of respirator you will use. (You can check more than one category).
    ☐ N, R or P disposable respirator (filter-mask, non-cartridge type only).
    ☐ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator? ☐ Yes ☐ No
    If "yes" what type(s)?

_____

_____

Clinic Copy

Part A. Section 2. (Mandatory)

Every employee who has been selected to use **any** type of respirator must answer questions 1 through 9 below.

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?
   - ☐ Seizures (fits)
   - ☐ Diabetes (sugar disease)
   - ☐ Allergic reactions that interfere with your breathing
   - ☐ Claustrophobia (fear of closed-in places)
   - ☐ Trouble smelling odors

3. Have you ever had any of the following pulmonary or lung problems?
   - ☐ 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

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   - ☐ 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 or 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

5. Have you ever had any of the following cardiovascular or heart problems?
   - ☐ 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

6. Have you ever had any of the following cardiovascular or heart 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 that is not related to eating
   - ☐ Any other symptoms that you think may be related to heart or circulation problems

7. Do you currently take medication for any of the following problems?
   - ☐ Breathing or lung problems
   - ☐ Heart trouble
   - ☐ Blood pressure
   - ☐ Seizures (fits)

8. If you've used a respirator, have you ever had any of the following problems?
   - ☐ Eye irritation
   - ☐ Skin allergies or rashes
   - ☐ Anxiety
   - ☐ General weakness or fatigue
   - ☐ Any other problem that interferes with your use of a respirator

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 15 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.

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?
   - ☐ Wear contact lenses
   - ☐ Wear glasses
   - ☐ Color blind
   - ☐ Any other eye or vision problem

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

13. Do you currently have any of the following hearing problems?
   - ☐ Difficulty hearing
   - ☐ Wear a hearing aid
   - ☐ Any other hearing or ear problem

14. Have you ever had a back injury?

15. Do you currently have any of the following musculoskeletal problems?
   - ☐ 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
   - ☐ 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

Respirator Physical Exam:

HEIGHT:	WEIGHT:	PULSE:	BLOOD PRESSURE (sitting):

Physical Exam	N	Ab	Physical Exam (cont.)	N	Ab
1. Eyes			**7. Beard/Mustache**		
2. Nose			**8. Neck**		
3. Oropharynx			**9. Lung**		
4. Teeth			**10. Hear**		
5. Outer Ear			**11. Extremities**		
6. Ear Canal			**12. TM's**		

Comments:

Initial/Periodic Hazmat Exam Questionnaire

1. Are you a member of a HAZ/MAT team?	☐ Yes	☐ No
2. Have you worn protective equipment (clothes, safety glasses, respirator, hearing protection)?	☐ Yes	☐ No
3. Have you participated in workplace medical monitoring (blood, urine, chest x-ray, respirator program?	☐ Yes	☐ No

Have you ever experienced any of the following symptoms or conditions due to workplace exposure?

1. Severe allergic reaction, difficulty breathing or swallowing	☐ Yes	☐ No
2. Heart pain, palpitations, heart muscle damage	☐ Yes	☐ No
3. Cough, shortness of breath, wheezing, asthma, lung damage, abnormal breathing tests or chest x-ray	☐ Yes	☐ No
4. Dizziness, fainting, blackouts, seizure, headaches, fatigue	☐ Yes	☐ No
5. Arm or leg weakness, numbness, pins/needles sensation	☐ Yes	☐ No
6. Abnormal liver blood tests, liver damage, hepatitis, weight loss, jaundice	☐ Yes	☐ No
7. Abdominal pain, stomach or intestinal problems, weight loss, blood in stool	☐ Yes	☐ No
8. Abnormal kidney blood or urine tests, kidney damage	☐ Yes	☐ No
9. Rash, skin cancer	☐ Yes	☐ No
10. Abnormal blood counts, anemia, swollen glands	☐ Yes	☐ No
11. Heat, cold illness, burns, frostbite	☐ Yes	☐ No
12. Difficulty with mood, memory, concentration	☐ Yes	☐ No

Have or have had any of the following medical conditions?

1. Hay fever, allergic rhinitis	☐ Yes	☐ No
2. Asthma, chronic bronchitis, COPD	☐ Yes	☐ No
3. Heart disease, congestive heart failure, hypertension, atrial fibrillation	☐ Yes	☐ No
4. Ulcers, Crohn's disease, diverticulitis	☐ Yes	☐ No
5. Hepatitis, cirrhosis, liver disease, gallbladder disease	☐ Yes	☐ No
6. Stroke, seizures, depression, anxiety, dementia, Parkinson's disease, multiple sclerosis	☐ Yes	☐ No
7. Leukemia, lymphoma, cancer	☐ Yes	☐ No
8. Another chronic/serious health condition	☐ Yes	☐ No
9. Any disability, physical limitation	☐ Yes	☐ No
10. Have you had any type of surgery	☐ Yes	☐ No

Have/had any of the following musculoskeletal conditions:

1. Back injury, strain, herniated disc, recurring ache ☐ Yes ☐ No
2. Neck problems, neck pain, whiplash ☐ Yes ☐ No
3. Bursitis, tendonitis ☐ Yes ☐ No
4. Foot or ankle problems ☐ Yes ☐ No
5. Fractures ☐ Yes ☐ No
6. Hand, wrist, elbow problem ☐ Yes ☐ No
7. Knee or shoulder problems ☐ Yes ☐ No

What year was your last diphtheria/tetanus booster? _____

Have you completed the series of three Hepatitis B injections? ☐ Yes ☐ No

List all medications you are currently taking: _____

_____

_____

Previous Employment

Employer	Job Title	Dates Employed

Provider notes:

_____

_____

_____

Exposure history

Please **DESCRIBE** any of the following exposures that may have occurred in the course of previous or current employment, or as a result of ongoing hobbies:

Corrosive chemicals _____

Metals _____

Gases/Fumes/Vapors _____

Dust/Fibers _____

Pesticides _____

Plastics _____

Solvents _____

Petrochemicals _____

Other chemicals _____

Radiation _____

Noise, Heat, Cold or Vibration _____

Bacteria, Viruses, Fungi, other infectious agents _____

Pharmaceuticals _____

Height: ' "	Weight: lbs.	Pulse:	Blood pressure (sitting):

URINALYSIS (dip stick):	ABNORMAL FINDINGS:	VISION TEST:	COLOR VISION:
☐ Negative ☐ Positive	☐ Glucose ☐ Protein ☐ Blood	Distant (standard type only): _____ R _____L Near vision values: _____ R _____L ☐ With correction ☐ Without correction	☐ Ishihara ☐ Primary ☐ N ☐ A

Normal (N) Abnormal (A) Not performed (O)	N	A	O	ABNORMAL FINDINGS
1. Development				
2. Skin				
3. Eyes				
4. Ears				
5. Nose/sinuses				
6. Throat				
7. Teeth/gums				
8. Thyroid gland/neck				
9. Lymph glands				
10. Chest				
11. Lungs				
12. Heart				
13. Abdomen				
14. Inguinal rings				
15. Spine				
16. Extremities				
17. Neurological, general				
18. Personality, general				

Patient name:_____ **Date of visit:**_____ / _____ / _____
Month Day Year

Medical Clearance for Respirator Use

☐ Unrestricted respirator use

☐ Limited respirator use

- ☐ No exposure to immediately dangerous to life and health (IDLH) atmospheres. Because eardrums could not be visualized or are not intact, no exposure to IDLH atmospheres. If not visualized, ears can be cleaned and rechecked.
- ☐ No strenuous exertion while wearing a respirator.
- ☐ Claustrophobia may limit respirator use in certain tight or enclosed areas. A case by case assessment is recommended.
- ☐ Needs follow-up medical evaluation.

☐ No respirator use

Additional Requirements

- ☐ Should remove beard, mustache, sideburns or other facial hair that will interfere with use of respirator.
- ☐ Should have blood pressure rechecked.
- ☐ Wears eyeglasses, needs to be considered in respirator use.
- ☐ Use of contact lenses not allowed.
- ☐ Needs follow-up medical evaluation.

Further Comments

_____

_____

_____

_____

The examinee/employee has been informed of the results and a copy of this written recommendation has been provided.

Please contact your occupational health program coordinator for further recommendations if: a change occurs in workplace conditions such as the physical work effort, protective clothing used or increased temperature, placing greater physiological burden on the employee; or if the above-mentioned employee develops physical changes that may have an effect on the fit of the respirator such as significant weight gain or loss, change in dentures or facial surgery.

Examiner:_____ Signature:_____ Clearance date:_____ / _____ / _____
Month Day Year

Provider to Complete. Send Employer this page along with Surveillance Hazmat Form

Employer Copy