Silica Respirator Questionnaire

INTEGRATED, COMPREHENSIVE OCCUPATIONAL HEALTH SERVICES

A division of Summit Orthopedics for over 20 years

Patient Name: _____

Employer: _____

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. Sex: ☐ Male ☐ Female
2. Your height: _____ft. _____in.
3. Your weight: _____lbs.
4. Your job title: _____
5. A phone number where you can be reached by the health care professional who reviews this questionnaire (include area code):
(_____) _____ - _____
6. The best time to call you at this number: _____ a.m./p.m.
7. Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No
8. 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).
9. Have you worn a respirator? ☐ Yes ☐ No

   If "yes" what type(s)?

   _____

   _____

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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)

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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:

Clinic Use Only

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
11. In previous jobs, did you have any occupational exposure to respirable silica: ☐ Yes ☐ No
If yes, what was your job? _____

12. What is your current level of occupational exposure to respirable silica? _____
13. What is your current job? _____
14. What is your anticipated level of future occupational exposure to respirable silica? _____
15. Describe any personal protective equipment currently used, or to be used, to protect against respirable silica exposure:

_____

_____

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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:

Asphalt Roofing Materials _____

Concrete Products _____

Porcelain Enameling _____

Dental Lab _____

Foundries _____

JewelryMaking _____

Cut Stone _____

Pottery _____

Ready-mix Concrete _____

Railroads _____

Shipyards _____

Structural Clay Products _____

Support for Gas/Oil Operations _____

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Tuberculosis Testing Documentation

Patient information:

Patient Label

EMPLOYEE TO FILL OUT

1. Have you ever had a previous Mantoux test? ☐ Yes ☐ No If Yes, when? _____
2. What were the results? ☐ Positive ☐ Negative
3. Were you ever treated for TB? ☐ Yes ☐ No If Yes, when? _____

Employee/Applicant signature: _____ Date: ____ / ____ / ____ (Month / Day / Year)

NURSE/MA TO FILL OUT

Employee receiving:

☐ TB History Questionnaire ☐ 2-Step Mantoux (baseline) ☐ 1-Step Mantoux (annual) ☐ Quantiferon

2-Step TST Administration

#1 Date:	Time:	Lot: Exp:	Location:	Given By:
#2 Date:	Time:	Lot: Exp:	Location:	Given By:

TST Reading

Date:	Time:	Result (mm)	Read by:
Date:	Time:	Result (mm)	Read by:

QUANTIFERON TB Blood Test

Name of TB blood test	Quantiferon TB Test
Date of blood draw	
RESULTS	
Interpretation of reading	☐ Positive ☐ Negative ☐ Indeterminate
Laboratory	Medtox Laboratories

Tuberculosis History Questionnaire

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Patient Label

Early Detection of Tuberculosis

This questionnaire gives guidance in identifying individuals with suspected or confirmed TB so that the appropriate controls can be promptly initiated.

Complete the questions in parts 1-3. Please answer these questions to the best of your knowledge.

TB History (Part 1)

1. Have you ever had a positive TB Skin Test? ☐ Yes ☐ No ☐ Don't know
2. Have you ever had an abnormal Chest X-ray? ☐ Yes ☐ No ☐ Don't know
3. Have you recently had the mucus you cough up tested for TB? ☐ Yes ☐ No ☐ Don't know
   - If yes, were you told it was positive? ☐ Yes ☐ No ☐ Don't know
4. Have you ever been told you have Infectious Tuberculosis? ☐ Yes ☐ No ☐ Don't know
   - If yes, how long ago? _____
5. Have you ever been treated with medication for Infectious TB? ☐ Yes ☐ No ☐ Don't know
   - If yes, how many medications? (check one) ☐ 1 ☐ 2 ☐ 2+
   - Are you still taking TB medicine? ☐ Yes ☐ No
   - Did you take all the medicine until the health care professional said you were done? ☐ Yes ☐ No
6. Do you live with/have you been in close contact with someone who was recently diagnosed with TB? ☐ Yes ☐ No ☐ Don't know

Current Symptoms (Part 2)

1. Do you have a cough that has lasted longer than three weeks? ☐ Yes ☐ No
2. Do you cough up blood or mucus? ☐ Yes ☐ No
3. Have you lost your appetite? Aren't hungry? ☐ Yes ☐ No
4. Have you lost weight (more than 10 lbs) in the last two months without trying to? ☐ Yes ☐ No
5. Do you have night sweats (need to change bedclothes because they are wet)? ☐ Yes ☐ No
6. Do you have any of the following: ☐ fatigue ☐ fever ☐ chills ☐ chest pain

   If yes, please explain: _____

Mantoux Step 1 Current Patient Status (Part 3)

Are you currently taking any medications? ☐ Yes ☐ No

- If yes, list here _____

Are you currently pregnant? ☐ Yes ☐ No

Employee/Applicant signature: _____ Date: ____ / ____ / ____ (Month / Day / Year)

ANSWER THE BELOW QUESTIONS AT THE TIME OF YOUR 2ND MANTOUX TEST (If Step 2 is required)

Mantoux Step 2 Current Patient Status

Are you currently taking any medications? ☐ Yes ☐ No

- If yes, list here _____

Are you currently pregnant? ☐ Yes ☐ No

Employee/Applicant signature: _____ Date: ____ / ____ / ____ (Month / Day / Year)

Evaluator comments: _____

Chest X-ray preliminary reading: ☐ Negative ☐ Positive ☐ Undetermined

☐ Person meets criteria and should be treated for latent TB ☐ Person shows no signs or symptoms of active TB

Physician signature: _____ Date: ____ / ____ / ____

Send to employer.

Minnesota Occupational Health

St. Paul | Blaine | Eagan | Shakopee | mohonline.com

EMPLOYEE AUTHORIZATION FOR CRYSTALLINE SILICA OPINION TO EMPLOYER

This medical examination for exposure to crystalline silica could reveal a medical condition that results in recommendations for (I) limitations on respirator use, (2) limitations on exposure to crystalline silica, or (3) examination by a specialist in pulmonary disease or occupational medicine. Recommended limitations on respirator use will be included in the written opinion to the employer. If you want your employer to know about limitations on crystalline silica exposure or recommendations for a specialist examination, you will need to give authorization for the written opinion to the employer to include one or both of those recommendations.

I hereby authorize the clinic to send the employer the following information, (please check all that apply):

1. O Clearance or restrictions involving working with crystalline silica
   (employee initial)_____

2. O Recommendation for a specialist examination
   (employee initial)_____

OR

3. O I do not authorize the opinion to the employer to contain anything other than recommended limitations on respirator use.
   (employee initial)_____

Please read and sign below:

I understand that if I select #3 above, I do not authorize my employer to receive the recommendation for specialist examination, the employer **will not be responsible** for arranging and covering costs of a specialist examination.

_____
Name (printed)

_____ _____
Signature

Send to employer.

Silica and Respirator Surveillance

Written Medical Opinion for Employer

EMPLOYER: ----------

EMPLOYEE NAME: _____ **DATE OF EXAMINATION:** _____

TYPE OF EXAMINATION: [ ] Initial examination **[ ]** Periodic examination **[ ]** Specialist examination

[ ] Other----------

USE OF RESPIRATOR:
[ ] No limitations on respirator use
[ ] Recommended limitations on use of respirator:_____

Dates for recommended limitations, if applicable: _____ to _____
MM/DD/YYYY MM/DD/YYYY

THIS SECTION WILL BE COMPLETED ONLY IF EMPLOYEE RELEASES THE INFORMATION FROM PAGE 8, #1 and/or #2
The employee has provided written authorization for disclosure of the following to the employer (if applicable):

1.[ ] I recommend that this employee should be examined by a Board Certified Specialist in Pulmonary Disease. 2.[ ] Recommended limitations on exposure to respirable crystalline silica: _____

_____

Dates for exposure limitations noted above: _____ to _____
MM/DD/YYYY MM/DD/YYYY

NEXT PERIODIC EVALUATION: [ ] 3 years [ ] Other: _____
MM/DD/YYYY

Examining Provider: Provider _____ (signature) Date: _____

Name: _____ Provider's specialty: _____

Office Address: _____ Office Phone: _____

[ ] I attest that the results have been explained to the employee.

The following is required to be checked by the Physician or other licensed Health Care Professional (PLHCP):
[ ] I attest that this medical examination has met the requirements of the medical surveillance section of the OSHA Respirable Crystalline Silica standard(§ 1910.1053(h) or 1926.1153(h)).

Send to employer.

Silica and Respirator Surveillance

WRITTEN MEDICAL REPORT FOR EMPLOYEE

EMPLOYEE NAME: _____ **DATE OF EXAMINATION:** _____

Email or mailing address of employee to send this employee report:_____

TYPE OF EXAMINATION:

[ ] Initial examination [ ] Periodic examination [ ] Specialist examination [ ] Other _____

RESULTS OF MEDICAL EXAMINATION:

Physical Examination-	[ ] Normal	[ ] Abnormal (see below)	[ ] Not performed
Chest Xray -	[ ] Normal	[ ] Abnormal (see below)	[ ] Not performed
Breathing Test (Spirometry) -	[ ] Normal	[ ] Abnormal (see below)	[ ] Not performed
Test for Tuberculosis-	[ ] Normal	[ ] Abnormal (see below)	[ ] Not performed
Other:_____	[ ] Normal	[ ] Abnormal (see below)	[ ] Not performed

Results reported as abnormal: _____

_____

_____

_____

_____

RECOMMENDATIONS:

[ ] No limitations on respirator use

[ ] Recommended limitations on use of respirator: _____

[ ] Recommended limitations on exposure to respirable crystalline silica: _____

_____

Dates for recommended limitations, if applicable: _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

[ ] I recommend that this employee should be examined by a Board Certified Specialist in Pulmonary Disease.

[ ] Other recommendations*:

_____

_____

Your next periodic examination for silica exposure should be in: [ ] 3 years [ ] Other: _____

Examining Provider: _____ (signature) Date: _____ (MM/DD/YYYY)

Provider Name: _____

Office Address: Minnesota Occupational Health Office Phone: (651) 968-5300

*These findings may not be related to respirable crystalline silica exposure or may not be work-related, and therefore may not be covered by the employer. These findings may necessitate follow-up and treatment by your personal physician.

Respirable Crystalline Silica standard(§ 1910.1053 or 1926.1153)

Send to employee.