Appendix B

Hampshire College
Respiratory Protection Program

MEDICAL QUESTIONNAIRE
Annual Respirator User Medical Questionnaire

Can you read (circle one): Yes/ No
If you have trouble reading this questionnaire, please ask for assistance.

Your employer must allow you to answer this questionnaire during normal work 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.

The questionnaire will be reviewed by the medical personnel at the Work Connection at Holyoke Medical Center.. The Work Connection can be reached at (413) 534-2546. An envelope has been provided with this questionnaire. When you have completed the questionnaire, place it in the envelope, seal it, and return it to Environmental Health & Safety for submission to the Work Connection.

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).

1. Today's date:_____
2. Your name :_____
3. Your age:_____
4. Sex (circle one): 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 phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire (see text above) (circle one): Yes/ No

11. Check the type of respirator you will use (you can check more than one category):
    b. _____ Disposable respirator (filter mask, non-cartridge type only)
    c. _____ Other type (for example, half- or full-face piece type, powdered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator before (circle one): Yes/ No
13. If "yes", what type(s):

_____
_____
_____
_____

Part A. Section 2. (Mandatory) Questions in this part 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
2. Have you ever had one 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
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 other chest injuries or surgeries: Yes/ No
    l. Any other lung problems 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 in 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 you think may be related to lung problems: Yes/No
5. Have you 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 problems 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 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
8. If you've used a respirator, have you ever had one 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 and 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
10. 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 bend forward or backward at the waist: Yes/ No
    e. Difficulty moving your head up or down: Yes/ No
    f. Difficulty 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 ladder carrying more than 25 lbs.: Yes/ No
    j. Any muscle or skeleton problem that interferes with using a respirator: Yes/ No
11. How often are you expected to use the respirator(s)? (Circle "yes" or "no" for all answers that apply to you):
    a. Escape only (no rescue): Yes/ No
    b. Emergency rescues only: Yes/ No
    c. Less than once per month: Yes/No
    d. Less than once a week: Yes/No
    e. Once a week or more: Yes/No
    f. When wearing a respiratory, how long do you typically wear it?
        (i) Less than 1 hour: Yes/ No
        (ii) One to 4 hours: Yes/ No
        (iii) Over 4 hours per day: Yes/ No
12. During the period that you are using the respirator(s), is your work effort:
    a. Light (less that 200 kcal per hour): Yes/ No
    (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.)
    b. If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.
    c. Moderate (200 to 350 kcal per hour): Yes/ No
    (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.)
    d. If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

e. Heavy (above 350 kcal per hour): Yes/ No
(Examples of heavy work effort 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.).)
f. If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/ No
    a. If "yes," describe this protective clothing and/or equipment:
    _____
    _____
    _____
    _____
    _____
14. Will you be working under hot conditions: Yes/ No
15. Will you be working under humid conditions: Yes/ No
16. Describe the work you'll be doing while you're using your respirator(s):
    a. _____
    _____
    _____
    _____
17. Describe any special or hazardous conditions you might encounter when you're using respirator(s) (for example, confined spaces, life-threatening gases):
    a. _____
    _____
    _____
    _____
18. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well being of others (for example, rescue, security):
    a. _____
    _____
    _____

Part B. <u>Optional Questions</u>. You may answer these questions, if you would like a physician to consider them in his/her evaluation.

1. Have you ever worked with any of the materials, or under any of the conditions, listed below:
    a. Asbestos: Yes/ No
    b. Silica (e.g., in sandblasting): Yes/ No
    c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/ No
    d. Beryllium: Yes/ No
    e. Aluminum: Yes/ No
    f. Coal: Yes/ No
    g. Iron: Yes/ No
    h. Tin: Yes/ No
    i. Dusty environments: Yes/ No
    j. Any other hazardous exposures: Yes/ No
    k. If "yes," describe these exposures:
    _____
    _____
    _____
2. List any second jobs or side businesses you have:
    _____
    _____
    _____
    _____
3. List your previous occupations:
    _____
    _____
    _____
4. List your current and previous hobbies:
    _____
    _____
    _____
5. Have you been in the military services? Yes/ No
    a. If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/ No
6. Have you ever worked on a HAZMAT team? Yes/ No
7. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking other medications for any reason (including over-the-counter medications): Yes/ No