



Holland Medicenter

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Medical History For Respirator Physical

Employer: _____ Date: _____

Employee: _____ DOB: _____ SS#: _____

Sex: _____ Height: _____ Weight: _____ Job Title: _____

Phone number: _____ Best Time You Can Be Reached At This Number: _____

Has your employer told you how to contact the healthcare professional who will review this questionnaire? Yes No

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: _____ Other type (for example, half- or full-facepiece type, powered air Purifying, supplied air, self-contained breathing apparatus).

Have you ever worn a respirator: Yes No

If "Yes", what type(s):

Questions 1 through 9 below must be answered by every employee who has been selected to use any type or respirator. Please circle "Yes" or "No".

Yes NO

- | | | |
|-------|-------|-----------------------------------------------------------------------------------------------|
| _____ | _____ | 1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? |
| _____ | _____ | 2. Have you ever had any of the following conditions? |
| _____ | _____ | Seizures (fits) |
| _____ | _____ | Diabetes (sugar diabetes) |
| _____ | _____ | Allergic reaction that interfered with your breathing |
| _____ | _____ | Claustrophobia (fear of closed-in spaces) |
| _____ | _____ | 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 illnesses? |
| _____ | _____ | 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 people at an ordinary pace on level ground. |
| _____ | _____ | Have to stop for breath when walking at an ordinary pace on level ground. |
| _____ | _____ | Shortness of breath when washing or dressing self. |

Yes **No**

- _____ _____ 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 you have been told about.

6. Have you ever had any of the following cardiovascular or heart symptoms?

- _____ _____ Frequent pain or tightness in the 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 you think may be related to heart or circulation problems.

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

- _____ _____ Breathing or lung problems.
- _____ _____ Heart trouble.
- _____ _____ Blood pressure.
- _____ _____ Seizures (fits).

8. If you have used a respirator, have you ever had any of the following problems? (If you have never used a respirator, check the following space and go to question 9)

- _____ _____ Eye irritation.
- _____ _____ Skin allergies or rashes.
- _____ _____ Anxiety.
- _____ _____ General weakness or fatigue.
- _____ _____ Any other problems that interferes with your use of the respirator.

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

Questions 10 to 15 must be answered by every employee who has been selected to use either a full-face respirator or a self contained breathing apparatus (SCBA). For employees who have been asked 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 problems.
12. Have you ever had an injury to your ears, including a broken ear drum?
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 or legs.
Pain or stiffness when you lean forward or backward at the waist.
Difficulty bending at the 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.
16. 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?
- If "Yes", do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you are working under these circumstances?
17. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (Example: gases, fumes, or dust), or have you come into skin contact with hazardous chemicals?

If "Yes", What?

18. Have you ever worked with any of the materials, or under any of the conditions listed below?
Asbestos.
Silica (ex. in sandblasting).
Tungsten/cobalt (ex. grinding or welding this material).
Beryllium.
Aluminum.
Coal (ex. mining).
Iron.
Tin.
Dusty environments.
Any other hazardous exposure.

If "Yes", describe these exposures:

19. Have you been in the military services?
If "Yes", were you exposed to biological or chemical agents (either in training or combat)?

20. List any previous occupations including second jobs and side businesses:

Yes No

____ 21. Are you taking any other medications other than the ones mentioned above?

If "Yes", name the medication if you know them:

____ 22. Will you be using any of the following items with your respirator?

- ____ HEPA Filters.
- ____ Canisters (for example, gas masks).
- ____ Cartridges.

____ 23. How often are you expected to use the respirator(s) (circle "Yes" or "No" for all that apply to you.

- ____ Escape only (no rescue).
- ____ Emergency rescue only.
- ____ Less than 5 hours per week.
- ____ Less than 2 hours per day.
- ____ 2 to 4 hours per day.
- ____ Over 4 hours per day.

____ 24. During the period you are using the respirator(s), is your work effort:

____ Light (less than 200 Kcal per hour)

If "Yes", how long does this period last during the average shift: _____ hrs _____ mins.

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.

____ Moderate (200 – 350 kcal per hour)

If "Yes", how long does this period last during the average shift: _____ hrs _____ mins.

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; a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

____ Heavy (above 350 kcal per hour)

If "Yes", how long does this period last during the average shift: _____ hrs _____ mins.

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.).

____ 25. Will you be wearing other protective clothing and/or equipment when using the respirator?

If "Yes", describe this protective clothing and/or equipment:

____ 26. Will you be working under hot or humid conditions?

27. Describe any special or hazardous conditions you might encounter when you are using your respirator(s) (for example, confined spaces, life-threatening gases):

I certify that I have answered truthfully questions regarding my health history and have not knowingly withheld any information concerning my health status or exposure to chemicals either past or present.

EMPLOYEE SIGNATURE

DATE



PFT Questionnaire

Name _____ Today's Date _____

Employer _____ Birth Date _____ SSN _____

Race: African-American Caucasian Hispanic Other: _____

- 1. Smoking? Never Quit <1 yr Quit 1+ yrs Smoker
- 2. Have you experienced any new chest or breathing problems in the last month?..... YES NO
- 3. Are you in pain or do you feel ill in anyway?..... YES NO
- 4. Have you had any surgery or hospitalization in the past 4 weeks?..... YES NO
- 5. Have you eaten a large meal in the past hour?..... YES NO
- 6. Have you exercised vigorously in the past hour?..... YES NO
- 7. Do you currently have allergies that affect nose/sinus/breathing (hay fever)?..... YES NO
- 8. Do you have asthma?..... YES NO
- 9. Do you have a respiratory infection?..... YES NO
- 10. Have you had influenza or severe cold in the past 3 weeks?..... YES NO
- 11. Are you wearing any tight or restrictive clothing?..... YES NO
- 12. Have you used inhaler (bronchodialator) in the past hour?..... YES NO
- 13. Do you have a chronic cough (every day for the past 2 months)?..... YES NO

Please remove anything you may have in your mouth including gum, candy, tongue ring, etc.

I herby certify that I have fully read the above questions and that my answers are true and correct.

Employee Signature _____ Date _____