



# 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 (circle one): 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