

Ithaca College Medical Evaluation Questionnaire

For Employees Who Wear Respirators

Can you read English? YES / NO

Wearing a respirator may place a physiologic burden on employees that varies with the type of respirator worn, the job and workplace conditions in which the respirator is used, and the medical status of the employee. Ithaca College will provide a medical evaluation to determine the employee's ability to safely use a respirator before the employee is fit-tested or he or she uses a respirator at work. The medical evaluation shall meet all requirements specified in the OSHA Respiratory Protection Standard (29 CFR Part 1910.134).

IMPORTANT

Ithaca College 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.

PROCEDURE:

- 1) Answer all questions on this form as accurately and completely as possible.
- 2) Print your answers clearly.
- 3) When finished, bring the questionnaire to the Ithaca College Hammond Health Center or send it through intercampus mail at least three (3) business days before your scheduled medical consultation.
- 4) If you have any questions while completing this form, contact the health center at 274-3177.
- 5) The staff physicians or other licensed health care professionals of the Ithaca College health center will complete medical evaluations for respirator wearers. At a minimum, the initial medical evaluation shall consist of this screening questionnaire.
- 6) Follow-up medical examination will be provided for any employee who gives a positive response to any of questions 1-8 in Section II of the questionnaire, or whose medical evaluation indicates a need for follow-up examination. The examination will be provided through the Ithaca College health center and will include any medical tests, consultations, or diagnostic procedures that are deemed necessary to make a final determination.
- 7) Additional medical evaluations at the health center and, when appropriate, by other health care providers shall be provided if the employee reports medical symptoms associated with respirator use. The health center, the employee's supervisor, or the Office of Environmental Health and Safety (EH&S) may request re-evaluation if information from the respiratory protection program indicates a need for re-evaluation or that change must occur in workplace conditions.

Respirator Medical Evaluation Questionnaire

SECTION I:

Every employee who has been selected to use any type of respirator must provide the following information. (**Please print**)

1. Date _____

2. Name _____

3. Employee I.D. Number _____

4. Age (to the nearest year) _____

5. Sex (circle one): Male Female

6. Height _____ ft. _____ in.

7. Weight _____ lbs.

8. Job Title and Department _____

9. A phone number where you can be reached by the health center professional who reviews this questionnaire (include area code) _____

10. The best time to call you at this number _____

11. Has your employer told you how to contact the health center professional who will review this questionnaire? (circle one) Yes / No (See procedure on previous page.)

12. The type(s) of respirator(s) you will use (check all that apply):

_____ N, R, or P disposable respirator (i.e., dust mask or filter-mask, non-cartridge type only)

_____ Half-face cartridge type (air purifying)

_____ Full-face cartridge type (air purifying)

_____ Other(s): Powered-air purifying, supplied air, or self-contained breathing apparatus

13. Have you worn a respirator before? (circle one) Yes / No

If yes, what type(s)?

13A. If you currently wear a respirator on the job, indicate the duration and frequency of respirator use (e.g., once per week for one hour at a time, emergencies only, etc.).

13B. Describe the expected physical work effort associated with the job(s) you perform while wearing a respirator.

13C. List any additional protective clothing and equipment worn when using the respirator.

13D. Describe any temperature (greater than 77° F) and humidity extremes that may be encountered when wearing a respirator.

14. Have you had significant exposure to toxic or harmful materials in the workplace prior to your employment at Ithaca College? If yes, please list types and duration of exposure(s), and any known, documented, or diagnosed effect on your health.

SECTION II:

Every employee who has been selected to use any type of respirator must answer questions 1-9. (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 any of the following conditions?

a) Seizures (epilepsy, 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

f) Significant kidney or bladder disease Yes / No

g) Severe arthritis Yes / No

h) Jaundice 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 chest injuries or surgeries Yes / No
- l) Any other lung problem 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) Must 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 with 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 ever 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 problem 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 or 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 any of the following problems?

(If you've never used a respirator, check the following space and go to Question 9)

_____ I have never used a respirator.

a) Eye irritation Yes / No

b) Skin allergies or rashes Yes / No

c) Anxiety Yes / No

d) General weakness or fatigue Yes / No

e) Any other problems that interfere 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? Yes / No

Questions 10 to 15 below 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?

a) Wear contact lenses Yes / No

b) Wear glasses Yes / No

c) Color blind Yes / No

- d) Are there any other eye or vision problems? Yes / No
12. Have you ever had an injury to your ears, including a broken eardrum? Yes / No
13. Do you currently have any of the following hearing problems?
- a) Difficulty hearing Yes / No
- b) Wear a hearing aid Yes / No
- c) Any other hearing or ear problems Yes / No
14. Have you ever had a back injury? Yes / No
15. 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 lean forward or backward at the waist Yes / No
- e) Difficulty fully moving your head up or down Yes / No
- f) Difficulty fully 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) Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs. Yes / No
- j) Any other muscle or skeletal problems that interfere with using a respirator Yes / No
16. How often are you expected to use the respirator(s)?
- a) Escape only (no rescue) Yes / No
- b) Emergency rescue only Yes / No
- c) Less than 5 hours per week Yes / No
- d) Less than 2 hours per day Yes / No
- e) Between 2 to 4 hours per day Yes / No
- f) Over 4 hours per day Yes / No
17. During the period you are using the respirator(s), is your work effort:
- a) "Light" (less than 200 kcal per hour)? Yes / No
- If yes, how long does this period last during the average shift? _____ Hrs ___ Min

Examples of a light-work effort: sitting while writing, typing, drafting, performing light assembly work; or standing while operating a drill press (1-3 lbs.), or controlling machines.

b) "Moderate" (200 to 350 kcal per hour)? Yes / No

If yes, how long does this period last during the average shift? _____ Hrs ___ Min

Examples of moderate-work effort: sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, 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.

c) "Heavy" (above 350 kcal per hour)? Yes / No

If yes, how long does this period last during the average shift? _____ Hrs ___ Min

Examples of heavy work: 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 with a heavy load (about 50 lbs.)

18. Will you be wearing protective clothing or equipment (other than the respirator) when you're using your respirator? Yes / No

If yes, describe this protective clothing and equipment.

19. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (e.g., confined spaces, life-threatening gases). _____

20. Describe any special responsibilities you will have while wearing your respirator(s) that may affect the safety and well-being of others (e.g., rescue, security, etc.).

21. Provide any other pertinent information that you feel would be helpful to the health care professional reviewing this form as it relates to wearing a respirator.

Employee Signature: _____ **Date:** _____

To be completed by the health care professional performing the medical evaluation

MEDICAL DETERMINATION

Medical Review by: (please print) _____ **Date:** _____

Reviewing Health Care Professional's Signature: _____

_____ **Employee is medically able to wear respirator without limitations.**

_____ **Employee should only wear a respirator with the following limitations or conditions:**

_____ **Employee is NOT medically able to wear a respirator under any circumstances.**

_____ **Additional medical evaluations, tests, or other procedures are required to make a determination regarding the employee's medical ability to wear a respirator. See list or description below:**

Note to Physician: A copy of this medical determination form must be provided to the employee and Environmental Health and Safety. (Do not include any confidential medical information with correspondence to EH&S.)

Copies sent to:

_____ Employee (print name) _____

_____ Environmental Health and Safety