MANDATORY RESPIRATOR EVALUATION
MEDICAL QUESTIONNAIRE *(Long Form)*

SECTION 1. MANDATORY *(The following information must be provided by every employee)*

1. Today's date: _____

2. Your name: _____

3. Your employee number: _____

4. Date of birth: _____ **Your age** *(to nearest year)*: _____

5. Sex : ☐ Male ☐ Female

6. Your height: _____ feet _____ inches

7. Your weight: _____ lbs.

8. Your job title: _____

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

10. The best time to phone you at this number: _____

11. Has your employer told you how to contact the health care professional who will review this questionnaire? *(see cover letter)* ..... **Yes** ☐ **No** ☐

12. Indicate the type of respirator you will use: *(you can check more than one category)*

- ☐ Disposable particulate filtering facepiece, "dust mask"
- ☐ Half facepiece
- ☐ Full facepiece
- ☐ Powered air-purifying
- ☐ Supplied-air
- ☐ Self-contained breathing apparatus
- ☐ I currently do not wear a respirator

13. If you currently do not wear a respirator but have worn one in the past (to include jobs before Nalco), what type did you wear? *(you can check more than one category)*

- ☐ Never worn a respirator before
- ☐ Disposable particulate filtering facepiece, "dust mask"
- ☐ Half facepiece
- ☐ Full Facepiece
- ☐ Powered air-purifying
- ☐ Supplied-air
- ☐ Self-contained breathing apparatus

14. Have you completed a Nalco respirator medical exam? ..... **Yes** ☐ **No** ☐

Approximate date: _____

15. If you answered *YES* to Question 14, have there been health or medical changes since the last respiratory exam? ..... **Yes** ☐ **No** ☐

If so, explain: _____

_____

_____

SECTION 2. Mandatory *(Questions 1 through 9 below must be answered by every employee)*

	Yes	No
1. Have you *ever* smoked tobacco products?	☐	☐

If ***YES***: How long have you smoked or did you smoke?_____ Years

How much have you averaged or did you average?

Cigarettes:_____ packs per ☐ day ☐ week ☐ month

Cigars:_____ cigars per ☐ day ☐ week ☐ month

Pipe tobacco:_____ ounces per ☐ day ☐ week ☐ month

What and how much do you smoke at present?_____

If you have quit smoking, when did you quit? _____

2. Have you *ever had* any of the following conditions?	Yes	No
a. Seizures *(fits)*	☐	☐
b. Diabetes *(sugar disease)*	☐	☐
c. Allergic reactions that interfere with your breathing	☐	☐
d. Claustrophobia *(fear of closed-in places)*	☐	☐
e. Trouble smelling odors	☐	☐

3. Have you *ever had* any of the following pulmonary or lung problems?	Yes	No
a. Asbestosis	☐	☐
b. Asthma	☐	☐
c. Chronic bronchitis	☐	☐
d. Emphysema	☐	☐
e. Pneumonia	☐	☐
f. Tuberculosis	☐	☐
g. Silicosis	☐	☐
h. Pneumothorax *(collapsed lung)*	☐	☐
i. Lung cancer	☐	☐
j. Broken ribs	☐	☐
k. Any chest injuries or surgeries	☐	☐
l. 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?	Yes	No
a. Shortness of breath	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground	☐	☐
d. Have to stop for breath when walking at your own pace on level ground	☐	☐
e. Shortness of breath when washing or dressing yourself	☐	☐
f. Shortness of breath that interferes with your job	☐	☐
g. Coughing that produces phlegm *(thick sputum)*	☐	☐
h. Coughing that wakes you early in the morning	☐	☐
i. Coughing that occurs mostly when you are lying down	☐	☐
j. Coughing up blood in the last month	☐	☐
k. Wheezing	☐	☐
l. Wheezing that interferes with your job	☐	☐
m. Chest pain when you breathe deeply	☐	☐
n. 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?	Yes	No
a. Heart attack	☐	☐
b. Stroke	☐	☐
c. Angina	☐	☐
d. Heart failure	☐	☐
e. Swelling in your legs or feet *(not caused by walking)*	☐	☐
f. Heart arrhythmia *(heart beating irregularly)*	☐	☐
g. High blood pressure	☐	☐
h. Any other heart problem that you've been told about	☐	☐

6. Have you *ever had* any of the following cardiovascular or heart symptoms?	Yes	No

	Yes	No
a. Frequent pain or tightness in your chest	☐	☐
b. Pain or tightness in your chest during physical activity	☐	☐
c. Pain or tightness in your chest that interferes with your job	☐	☐
d. In the past two years, have you noticed your heart skipping or missing a beat	☐	☐
e. Heartburn or indigestion that is not related to eating	☐	☐
f. 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?	**Yes**	**No**
a. Breathing or lung problems	☐	☐
b. Heart trouble	☐	☐
c. Blood pressure	☐	☐
d. Seizures *(fits)*	☐	☐

	Yes	**No**
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 ☐		
a. Eye irritation	☐	☐
b. Skin allergies or rashes	☐	☐
c. Anxiety	☐	☐
d. General weakness or fatigue	☐	☐
e. Any other problem that interferes with your use of a respirator	☐	☐

9. Would you like to talk to a health care professional who will review this questionnaire about your answers to the questionnaire?	**Yes** ☐	**No** ☐

Please comment about any **YES** responses to Questions 1 through 9: _____

_____

_____

SECTION 3. MANDATORY WORKLOAD QUSTIONNAIRE

	Yes	**No**
1. 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're working under these conditions?	☐	☐
2. At work or at home, have you ever been exposed to hazardous solvents hazardous airborne chemicals *(e.g. gases, fumes, or dust)*, or have you come into skin contact with hazardous chemicals?	☐	☐

If **YES**: Name the chemicals if you know them: _____

_____

_____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below?	**Yes**	**No**
a. Asbestos	☐	☐
b. Silica *(e.g., in sandblasting)*	☐	☐
c. Tungsten/cobalt *(e.g., grinding or welding this material)*	☐	☐
d. Beryllium	☐	☐
e. Aluminum	☐	☐
f. Coal *(for example, mining)*	☐	☐
g. Iron	☐	☐
h. Tin	☐	☐
i. Dusty environments	☐	☐
j. Any other hazardous exposures	☐	☐

If **YES**: Describe these exposures: _____

_____

_____

4. List any second jobs or side businesses you have: _____

_____

_____

5. List your previous occupations: _____

_____

_____

6. List your current and previous hobbies: _____

_____

_____

	Yes	No
7. Have you been in the military services?	☐	☐
If **YES**: Were you exposed to biological or chemical agents *(either in training or combat)*?	☐	☐
8. Have you ever worked on a HAZMAT team?	☐	☐
9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason *(including over-the-counter medications)*?	☐	☐

If **YES**: Name the medications, if you know them: _____

_____

_____

10. Will you be using any of the following items with your respirator(s)?	Yes	No
a. HEPA Filters	☐	☐
b. Canisters (for example, gas masks)	☐	☐
c. Cartridges	☐	☐

11. How often are you expected to use the respirator(s):

- ☐ I do not currently use a respirator.
- ☐ Escape only
- ☐ Emergency rescue
- ☐ Disposable particulate filtering facepiece, "dust mask"
- ☐ Half facepiece
- ☐ Full facepiece
- ☐ Powered air-purifying
- ☐ Supplier-air
- ☐ Self-contained breathing apparatus

Select only one of the following, if applicable:

- ☐ Less than 5 hours *per week*
- ☐ Less than 2 hours *per day*
- ☐ 2 to 4 hours *per day*
- ☐ Over 4 hours *per day*

	Yes	No
12. Will you be wearing protective clothing and/or equipment *(other than the respirator)* when you are using your respirator?	☐	☐

If **YES**: Describe this protective clothing and/or equipment: _____

_____

_____

	Yes	No
13. Will you be working under hot conditions *(temperature exceeding 77°F)*?	☐	☐
14. Will you be working under humid conditions?	☐	☐

SECTION 4. To be completed by employees wearing full facepiece respirators or a self contained breathing apparatus (SCBA) only.

	Yes	No
1. Have *you ever* lost vision in either eye *(temporarily or permanently)*?	☐	☐
2. Do you *currently* have any of the following vision problems?	**Yes**	**No**
a. Wear contact lenses	☐	☐
b. Wear glasses	☐	☐
c. Color blind	☐	☐
d. Any other eye or vision problem	☐	☐
	Yes	**No**
3. Have you *ever had* an injury to your ears, including a broken ear drum?	☐	☐
4. Do you *currently* have any of the following hearing problems?	**Yes**	**No**
a. Difficulty hearing	☐	☐
b. Wear a hearing aid	☐	☐
c. Any other hearing or ear problem	☐	☐
	Yes	**No**
5. Have you *ever had* a back injury?	☐	☐
6. Do you *currently* have any of the following musculoskeletal problems?	**Yes**	**No**
a. Weakness in any of your arms, hands, legs, or feet	☐	☐
b. Back pain	☐	☐
c. Difficulty fully moving your arms and legs	☐	☐
d. Pain or stiffness when you lean forward or backward at the waist	☐	☐
e. Difficulty fully moving your head up or down	☐	☐
f. Difficulty fully moving your head side to side	☐	☐
g. Difficulty bending at your knees	☐	☐
h. Difficulty squatting to the ground	☐	☐
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.	☐	☐
j. Any other muscle or skeletal problem that interferes with using a respirator	☐	☐

7. Please explain any *YES* answers: _____

_____

_____