# Appendix A
# Medical Questionnaire & Cover Sheet

**EMPLOYEE -- Respirator Medical Evaluation Questionnaire**
*Adapted from Appendix C to Sec. 1910.134: OSHA*

In order to meet the requirements in the Dartmouth College Respiratory Protection Program, you must complete the following questionnaire annually, after which it will be reviewed by a licensed clinical provider at Dick's House (646-9400) and then put into your Medical Record. Thank you.

**INSTRUCTIONS: Complete Section A below as well as the attached medical questionnaire.**

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**Section A**

**Employee Name**: ____________________________________________

**Employee ID Number:**________________________________________

**Dept**:______________________ **Supervisor**: _________________________

**Email:**______________________ **Phone:**_____________________________

**Job description while wearing respirator, to include estimated frequency and duration, expected airborne hazards:**_____________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

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A licensed healthcare provider at Dick's House will review the completed medical questionnaire. If you have questions or wish to discuss this evaluation with Dick's House, please call (603) 646-9400.

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## **Healthcare Provider Use Only** (Return form to EHS prior to fit test)

____ This individual is medically able to wear a respiratory device at this time.

____ This individual is NOT medically able to wear a respiratory device at this time.

**Health Service Provider signature:** ________________________________________

**Date of Review:** ___________________

*revised 2/2020*
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# Respiratory Protection Program, OSHA Mandatory Medical Questionnaire

1. Today's date: ____/____/______

| 2. Name (last, first, MI) | 3. Age (to nearest year) | 4. Sex | 5. Height _________ ft _______ in |
|---|---|---|---|
| 6. Weight Lbs. | 7. Job title | 8. Phone number where you can be reached by the health care professional who will review this questionnaire (include area code) | 9. Best time to phone you at this number: |
| 10. Has your employer told you how to contact the health care provider who will review this questionnaire? ________ yes ________ no | 11. Type(s) of respirator you will use (mark all that apply): 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 | | 12. Have you worn a respirator? ____ yes ____ no If yes, what type(s) |

| Medical History | YES | NO |
|---|---|---|
| ***Questions 1 through 9 below must be answered by every Employee who has been selected to use any type respirator. Please mark "X" yes or no for each.*** | | |
| **1. Do you currently smoke tobacco, or have you smoked tobacco during the past month?** | | |
| **2. Have you ever had any of the following conditions?** | | |
| a. seizures (fits, convulsions, epilepsy) | | |
| b. diabetes (high blood sugar disease) | | |
| c. allergic reactions that interfere with your breathing | | |
| d. claustrophobia (fear of closed-in places) | | |
| e. trouble smelling odors | | |
| f. latex (rubber) allergy | | |
| **3. Have you ever had any of the following pulmonary (lung) conditions?** | | |
| a. asbestosis | | |
| b. asthma | | |
| c. chronic bronchitis | | |
| d. emphysema | | |
| e. pneumonia | | |
| f. tuberculosis | | |
| g. silicosis | | |
| h. beryllium disease | | |
| i. sarcoidosis | | |
| j. pneumothorax (collapsed lung) | | |
| k. lung cancer | | |
| l. broken ribs | | |
| m. any chest injury or surgeries | | |
| n. any other lung problem that you've told about | | |
| **4. Do you currently have any of the following symptoms of pulmonary or lung disease?** | | |
| a. shortness of breath | | |
| b. shortness of breath when walking fast on level ground or walking normal speed 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 | | |

| Medical History continued | YES | NO |
|---|---|---|
| g. coughing that produces phlegm (thick sputum) | | |
| h. coughing that wakes you up 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 (heart) problems?** | | |
| a. heart attack | | |
| b. stroke | | |
| c. angina (heart pain) | | |
| d. heart failure | | |
| e. swelling in you legs or feet (not caused by walking) | | |
| f. heart arrhythmia (irregular heart beat) | | |
| g. high blood pressure | | |
| h. abnormal stress test -- approximate date: | | |
| i. cardiac (heart) catheterization – approximate date: | | |
| j. any other heart problem about which you have been told | | |
| **6. Have you ever had any of the following cardiovascular (heart) symptoms?** | | |
| 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 any medication for any of the following problems?** | | |
| a. breathing | | |
| b. heart trouble | | |
| c. blood pressure | | |
| d. seizures (fits, convulsions, epilepsy) | | |

***Continued on page 2.***

## Respiratory Protection Program, OSHA Mandatory Medical Questionnaire

| **Medical History continued** | **YES** | **NO** |
|---|---|---|
| Have you ever used a respirator? (If NO, skip to question 9.) | | |
| **8. If you have used a respirator, have you ever had any of the following problems?** | | |
| a. eye irritation | | |
| b. skin allergies or rashes | | |
| c. anxiety (caused by wearing respirator) | | |
| d. general weakness or fatigue | | |
| e. any other problem that interferes with your use of a respirator | | |
| **9. Would you like to talk to the healthcare professional who will review this questionnaire about your answers?** | | |
| ***Answer questions 10 through 15 below only if you use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA)*** | | |
| **10. Have you ever lost vision in either eye (temporarily or permanently)?** | | |
| **11. Do you currently have any of the following vision problems?** | | |
| a. wear contact lenses | | |
| b. wear glasses | | |
| c. color blind | | |
| d. 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?** | | |
| a. difficulty hearing | | |
| b. wear a hearing aid | | |
| c. 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?** | | |
| a. weakness in your arms, legs, hands, or feet | | |
| b. back pain | | |
| c. pain or stiffness when you lean forward or backward at the waist | | |
| d. difficulty fully moving your arms and legs | | |
| e. difficulty moving your head up or down | | |
| f. difficulty moving your head side-to-side | | |
| g. difficulty bending at your knees | | |
| h. difficulty squatting to the ground | | |
| i. difficulty climbing a flight of stairs or a ladder carrying more than 25 pounds | | |
| j. any other muscle or skeletal problem that interferes with using a respirator | | |
| **16. Any other health condition that you think may affect your ability to use a respirator safely? If YES, please specify condition:** | | |
| Signature of worker: | | |

| **Medical Clinic Use Only:** | **YES** | **NO** |
|---|---|---|
| Medically fit to wear respirator *Any positive responses to questions 1-8 of the Medical History portion or physician's recommendation require a follow-up medical examination. | | |
| Referred for further evaluation<br>If, YES, specify condition or concern: | | |

**Reviewed by:** ______________________________________________

**Date:** ____/____/_____

**Examiner's comments on positive responses:**

**Targeted physical exam** (performed upon physician's recommendation):

BP: _____/_____ Pulse: _______ Reg / Irreg

| | Normal | Abn |
|---|---|---|
| HEENT | | |
| Neck – incl. carotid upstrokes and JVD | | |
| Lungs | | |
| Heart | | |
| Extremities – incl. peripheral pulses and edema | | |
| Other – specify: | | |

| **Medically fit to wear respirator?** | **Yes** | **No** |
|---|---|---|
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