

If you have questions about this form, call USC Care at 213-740-072

Health History Questionnaire for Respirator Users

This questionnaire will be viewed and kept only by USC Care Medical Group.

This form follows OSHA guidelines and meets regulatory requirements.

EMPLOYEE: Answer the following questions to provide background information for the health professional.

Can you read? Yes No

Your employer 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, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date: _____
2. Your name: _____
3. Your date of birth: _____
4. Age (to nearest year): _____
5. Social Security Number: _____ (voluntary)
6. Sex: Male Female
7. Your height: _____ ft. _____ in.
8. Your weight: _____ lbs.
9. Your job title: _____
10. A phone number where you can be reached by the health care professional who reviews this questionnaire (include Area Code): _____
11. The best time to phone you at this number _____
12. Did your employer tell you how to contact the health care professional who will review this form? Yes No
13. Check the type of respirator you will use (you can check more than one category):
 N, R, or P disposable respirator (filter-mask, non-cartridge type only)
 Other type (for example, half- or full-facepiece type, supplied-air, self-contained breathing apparatus).
14. Have you ever worn a respirator? Yes No If "yes," what type(s)? _____
15. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes No
16. Have you ever had any of the following conditions?

	Seizures (fits)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Diabetes (sugar disease)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Allergic reactions that interfere with your breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Claustrophobia (fear of closed-in places)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Trouble smelling odors	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Have you ever had any of the following pulmonary or lung problems?

Asbestosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
			Silicosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumothorax (collapsed lung)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lung cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Broken ribs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any chest injuries or surgeries	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any other lung problem you've been told of	_____	

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18. Do you currently have any of the following symptoms of pulmonary or lung illness?
- | | | | |
|--|---------------------|---------|--------|
| | Shortness of breath | ___ Yes | ___ No |
| Shortness of breath when walking fast on level ground or walking up a slight hill or incline | | ___ Yes | ___ No |
| Shortness of breath when walking with other people at an ordinary pace on level ground | | ___ Yes | ___ No |
| Have to stop for breath when walking at your own pace on level ground | | ___ Yes | ___ No |
| Shortness of breath when washing or dressing yourself | | ___ Yes | ___ No |
| Shortness of breath that interferes with your job | | ___ Yes | ___ No |
| Coughing that produces phlegm (thick sputum) | | ___ Yes | ___ No |
| Coughing that wakes you early in the morning | | ___ Yes | ___ No |
| Coughing that occurs mostly when you are lying down | | ___ Yes | ___ No |
| Coughing up blood in the last month | | ___ Yes | ___ No |
| Wheezing | | ___ Yes | ___ No |
| Wheezing that interferes with your job | | ___ Yes | ___ No |
| Chest pain when you breathe deeply | | ___ Yes | ___ No |
| Any other symptoms that you think may be related to lung problems | | ___ Yes | ___ No |
19. Have you ever had any of the following cardiovascular or heart problems?
- | | | | |
|---|---------------|---------|--------|
| | Heart attack | ___ Yes | ___ No |
| | Stroke | ___ Yes | ___ No |
| | Angina | ___ Yes | ___ No |
| | Heart failure | ___ Yes | ___ No |
| Swelling in your legs or feet (not caused by walking) | | ___ Yes | ___ No |
| Heart arrhythmia (heart beating irregularly) | | ___ Yes | ___ No |
| High blood pressure | | ___ Yes | ___ No |
| Any other heart problem that you've been told about | | ___ Yes | ___ No |
20. Have you ever had any of the following cardiovascular or heart symptoms?
- | | | | |
|---|--|---------|--------|
| | Frequent pain or tightness in your chest | ___ Yes | ___ No |
| Pain or tightness in your chest during physical activity | | ___ Yes | ___ No |
| Pain or tightness in your chest that interferes with your job | | ___ Yes | ___ No |
| In the past two years, have you noticed your heart skipping or missing a beat | | ___ Yes | ___ No |
| Heartburn or indigestion that is not related to eating | | ___ Yes | ___ No |
| Any other symptoms that you think may be related to heart or circulation problems | | ___ Yes | ___ No |
21. Do you currently take medication for any of the following problems?
- | | | | |
|--|----------------------------|---------|--------|
| | Heart trouble | ___ Yes | ___ No |
| | Breathing or lung problems | ___ Yes | ___ No |
| | Blood pressure | ___ Yes | ___ No |
| | Seizures (fits) | ___ Yes | ___ No |
22. Have you ever had any of the following problems while using a respirator? *(If you have never used a respirator, place a check in the following space: _____, and go to question 9.)*
- | | | | |
|---|-----------------------------|---------|--------|
| | Eye irritation | ___ Yes | ___ No |
| | Skin allergies or rashes | ___ Yes | ___ No |
| | Anxiety | ___ Yes | ___ No |
| | General weakness or fatigue | ___ Yes | ___ No |
| Any other problem that interferes with your use of a respirator | | ___ Yes | ___ No |
23. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?
- | | | |
|--|---------|--------|
| | ___ Yes | ___ No |
|--|---------|--------|

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Section 2. Answering the following questions is mandatory for every employee who has been selected to use either a full-facepiece 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.

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

Section 3. Answering the following questions is voluntary, although your answers may enable the health care professional to provide a more complete assessment of your fitness to wear a respirator.

- 30. 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? Yes No
If "yes," name the chemicals if you know them: _____
- 31. List your previous occupations: _____
- 32. List your current and previous hobbies: _____
- 33. Have you been in the military services? Yes No
If "yes," were you exposed to biological or chemical agents (either in training or combat)? Yes No
- 34. Have you ever worked on a HAZMAT team? Yes No
- 35. Will you be wearing protective clothing or equipment (other than a respirator) when you're using your respirator?
 Yes No If "yes," describe this protective clothing / equipment: _____
- 36. Will you be working under hot conditions (temperature exceeding 77° F)? Yes No
- 37. Will you be working under humid conditions? Yes No
- 38. Describe the work you'll be doing while you're using your respirator(s): _____

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39. Have you ever worked with any of the materials, or under any of the conditions, listed to the right:
- | | | |
|---|---------|--------|
| Tin | ___ Yes | ___ No |
| Iron | ___ Yes | ___ No |
| Asbestos | ___ Yes | ___ No |
| Beryllium | ___ Yes | ___ No |
| Aluminum | ___ Yes | ___ No |
| Coal (for example, mining) | ___ Yes | ___ No |
| Silica (e.g., in sandblasting) | ___ Yes | ___ No |
| Tungsten/cobalt (e.g., grinding or welding this material) | ___ Yes | ___ No |
| Dusty environments | ___ Yes | ___ No |
| Any other hazardous exposures | ___ Yes | ___ No |

If "yes" to any, describe the exposures: _____

40. Other than medications for breathing or lung problems, heart trouble, blood pressure, or seizures mentioned earlier in this questionnaire, are you taking any medication for any reason (including over-the-counter medications)? ___ Yes ___ No

If "yes," name the medications if you know them: _____

41. How often are you expected to use the respirator(s)? (Check "yes" or "no" for all answers that apply to you):

- | | | |
|----------------------------|---------|--------|
| Escape only (no rescue) | ___ Yes | ___ No |
| Emergency rescue only | ___ Yes | ___ No |
| Less than 5 hours per week | ___ Yes | ___ No |
| Less than 2 hours per day | ___ Yes | ___ No |
| 2 to 4 hours per day | ___ Yes | ___ No |
| Over 4 hours per day | ___ Yes | ___ No |

42. During the period you use the respirator(s), is your work effort:

Light (less than 200 kcal per hour) ___ Yes ___ No

If "yes," how long does this period last during the average shift: _____ hours _____ minutes.

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 to 350 kcal per hour) ___ Yes ___ No

If "yes," how long does this period last during the average shift: _____ hours _____ minutes.

Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph; pushing a heavy load (about 100 lbs.) in a wheelbarrow on a level surface.

Heavy (above 350 kcal per hour) ___ Yes ___ No

If "yes," how long does this period last during the average shift: _____ hours _____ minutes.

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 at about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

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

44. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security): _____