

DOSH Medical Evaluation Questionnaire

Employer instructions:

- You may use on-line questionnaires if the requirements in WAC 296-842-14005 are met.
- You must tell your employee how to deliver or send the completed questionnaire to the health care provider you have selected.
- You must **NOT** review employees' questionnaires.

Health care provider's instructions:

- Review the information in this questionnaire and any additional information provided to you by the employer.
- You may add questions to this questionnaire at your discretion; **HOWEVER**, questions in Parts 1-3 may not be deleted or substantially altered.
- Follow-up evaluation is required for any positive response to questions 1-8 in Part 2, or questions 1-6 in Part 3. This might include: Phone consultations to evaluate positive responses, medical tests, and diagnostic procedures.
- When your evaluation is complete, send a copy of your written recommendation to the employer **AND** employee.

Employee information and instructions:

- Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you.
- Your employer or supervisor must not look at or review your answers at any time.

Part 1 - Employee Background Information

ALL employees must complete this part

Please print

1. Today's date:
2. Your name:
3. Your age (to nearest year):
4. Sex (circle one): Male / Female
5. Your height: ft. in.
6. Your weight: lbs.
7. Your job title:
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include Area Code):
9. The best time to call you at this number:
10. Has your employer told you how to contact the health care professional who will review this questionnaire?
Yes / No
11. Check the type of respirator(s) you will be using:
 a. N, R, or P filtering-facepiece respirator (for example, a dust mask, **OR** an N95 filtering-facepiece respirator).
b. Check all that apply.

Half mask Full facepiece mask Helmet hood Escape

Non-powered cartridge or canister

Powered air-purifying cartridge respirator (PAPR)

Supplied-air or Air-line

Self-contained breathing apparatus (SCBA): Demand or Pressure demand

Other:

12. Have you previously worn a respirator? Yes / No

If "yes," describe what type(s):

Part 2 - General Health Information
ALL employees must complete this part
Please 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 (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

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 have 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. Have to 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? Yes / No
- 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 have been told about: Yes / No
6. Have you *ever had* any of the following cardiovascular or heart symptoms? Yes / No
- 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 2 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? Yes / No
- 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 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: Yes / No
- b. Skin allergies or rashes: Yes / No
- c. Anxiety: Yes / No
- d. General weakness or fatigue: Yes / No
- e. Any other problem that interferes 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

Part 3 - Additional Questions for Users of Full-Facepiece Respirators or SCBAs
Please circle "Yes" or "No"

1. Have you *ever lost* vision in either eye (temporarily or permanently)? Yes / No
2. Do you *currently* have any of these vision problems? Yes / No
- a. Need to wear contact lenses: Yes / No
- b. Need to wear glasses: Yes / No
- c. Color blindness: Yes / No
- d. Any other eye or vision problem: Yes / No

3. Have you *ever had* an injury to your ears, including a broken ear drum? Yes / No
4. Do you *currently* have any of these hearing problems?
- a. Difficulty hearing: Yes / No
 - b. Need to wear a hearing aid: Yes / No
 - c. Any other hearing or ear problem: Yes / No
5. Have you *ever had* a back injury? Yes / No
6. 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. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes / No
 - j. Any other muscle or skeletal problem that interferes with using a respirator: Yes / No

Part 4 - Discretionary Questions

Complete questions in this part **ONLY IF your employer's health care provider says they are necessary**

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? Yes / No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you are working under these conditions: Yes / No

2. Have you ever been exposed (at work or home) to hazardous solvents, hazardous airborne chemicals (such as 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:

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

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:

7. 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

8. Have you ever worked on a HAZMAT team? Yes / No

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)? Yes / No

If “yes,” name the medications if you know them:

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

11. 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. 2 to 4 hours per day: Yes / No
f. Over 4 hours per day: Yes / No

12. 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. ___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.

b. *Moderate* (200 to 350 kcal per hour): Yes / No

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; 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. ___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.).

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

If “yes,” describe this protective clothing and/or equipment:

14. Will you be working under hot conditions (temperature exceeding 77°F): Yes / No

15. Will you be working under humid conditions:

Yes / No

16. Describe the work you will be doing while using your respirator(s):

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

18. Provide the following information, if you know it, for each toxic substance that you will be exposed to when you are using your respirator(s):

Name of the first toxic substance:

Estimated maximum exposure level per shift:

Duration of exposure per shift:

Name of the second toxic substance:

Estimated maximum exposure level per shift:

Duration of exposure per shift:

Name of the third toxic substance:

Estimated maximum exposure level per shift:

Duration of exposure per shift:

The name of any other toxic substances that you will be exposed to while using your respirator:

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