HASKELL
CORPORATION

RESPIRATOR MEDICAL HISTORY QUESTIONNAIRE
WAC Part E 296-62-07255

To the employer: You must not review employee questionnaires.

To the employee: COMPLETE EVERY SECTION

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 healthcare professional who will review it. BE SURE TO SIGN.

1. Name: (Last, First MI) _____ SSN _____	2. Your age (to nearest year)	3. Sex: Male Female 4. Your Height: ___ft ____in 5. Your Weight: _____lbs
6. Phone no. where you can be reached. 7. Best time to phone you at this number: 8. Have you ever worn a respirator? Yes ___ No ____ If yes, what type(s)?	Job Title: You may contact the LHCP reviewing this form: EXPRESS CARE ATTN: Occupational Medicine 4043 Northwest Ave Bellingham, WA 98226 Phone: (360) 734-4300 FAX: (360) 734-2128 Other:	9. Check the type of respirator you will use: (you can check more than one category) ____ N, P, or R disposable respirator (Filter mask, non–cartridge type only) ____ Half or full-face respirator ____ Supplied air respirator Today's Date:

PART A, SECTION 2 (MANDATORY) Question 1 through 9 below must be answered by every employee who has been selected to use any type of respirator.

	NO	YES
1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?		
2. Have you ever had any of the following conditions:		
Seizures (fits)?		
Diabetes (sugar disease)?		
Allergic reactions that interfere with breathing?		
Claustrophobia (fear of closed in places)		
3. Have you ever had:		
Asbestosis		
Asthma		
Chronic bronchitis		
Emphysema		
Pneumonia		
Tuberculosis		
Silicosis		
Pneumothorax (collapsed lung)		
Lung cancer		
Broken ribs		
Any chest injuries or surgeries		
Any other lung problem that you have been told about		
4. Do you have any of the following pulmonary or lung disease:		

	NO	YES
Shortness of breath		
Shortness of breath walking fast on level ground or walking up a slight hill or incline		
Shortness of breath walking with other people at an ordinary pace on level ground		
Have to stop for breath when walking at your own pace on level ground		
Shortness of breath when washing or dressing yourself		
Shortness of breath that interferes with your job		
Coughing that produces phlegm		
Coughing that wakes you early in the morning		
Coughing that occurs mostly when laying down		
Coughing up blood in the last month		
Wheezing		
Wheezing that interferes with your job		
Chest pain when you breath deeply		
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:		
Heart attack		
Stroke		
Angina		
Heart failure		

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	NO	YES
Swelling in your legs or feet (NOT caused by walking)		
High blood pressure or hypertension?		
Any other heart problem that you have been told about?		
6. Have you ever had any of the following:		
Frequent pain or tightness in your chest?		
Pain or tightness in your chest during physical activity?		
Pain or tightness in your chest that interferes with work?		
In the past two years have you noticed your heart skipping or missing a beat?		
Heartburn or indigestion that is not related to eating?		
Any other problems that you think may be related to heart or circulation problems?		
7. Do you currently take medication for any of the following:		
Breathing or lung problems?		
Heart trouble?		
Blood pressure?		
Seizures (Fits)?		
8. If you have used a respirator, have you ever had any of the following problems: (If you have never used a respirator, proceed to question 9)		
Eye irritation?		
Skin allergies or rashes?		
Anxiety?		
General weakness or fatigue?		
Any other problem interfering with respirator use?		
9. Would you like to talk to the health care professional who will review this questionnaire about your answers?		
10. Have you ever had lost vision in either eye (temporarily or permanently)?		

	NO	YES
11. Do you currently have any of the following vision problems:		
Wear contact lenses?		
Wear glasses?		
Color blind?		
Any other eye or vision problems?		
12. Have you ever had an injury to your ears, including a broken eardrum?		
13. Do you currently have any of the following hearing problems:		
Difficulty hearing?		
Wearing a hearing aid?		
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:		
Weakness in any of your arms, hands, legs or feet?		
Back pain?		
Difficulty fully moving your arms or legs?		
Difficulty moving your head fully up and down?		
Difficulty moving your head side to side?		
Difficulty bending at your knees?		
Difficulty squatting to the ground?		
Climbing a flight of stairs or a ladder while carrying more than 25 pounds?		
Any other musculoskeletal problems that interfere with respirator use? Explain below		

SUPPLEMENTAL INFORMATION FOR THE MEDICAL PROFESSIONAL REVIEWING THIS QUESTIONAIRE:

TYPE OF RESPIRATOR TO BE USED:

☐ Half Face (Cartridge) ☐ Full Face (Cartridge)
☐ Other air-purifying respirators, (Negative pressure) ☐ Powered air purifying respirators ☐ Supplied –air (SAR), airline respirators
☐ Self-contained breathing apparatus (SCBA) Positive pressure, continuous flow ☐ SCBA Pressure demand ☐ SCBA Escape only

DURATION AND FREQUENCY OF RESPIRATOR USE:

☐ Daily ☐ Occasionally, but more than once per week ☐ Rarely, or for emergencies/escape only

EXPECTED LEVEL OF PHYSICAL WORK EFFORT

☐ Light (Example: Standing while operating a drill press)
☐ Medium (Example: lifting about 35 pounds)
☐ Heavy (Example: Lifting about 50 pounds)

☐ Confined Space
☐ Hot environment
☐ Cold Environment

Describe workers' duties as related to exposure; identify potential hazardous materials:

_____

_____

Worker's exposure levels or anticipated exposure levels.

_____

_____

I certify that I have completed this questionnaire accurately and completely. I consent to a physical examination as required to determine my physical ability to safely use a respirator during my employment. I authorize the licensed healthcare professional to release to my employer the results of the medical examination as they may pertain to my physical ability to safely use a respirator under the proposed conditions. A photographic copy of this authorization shall be valid as the original.

EMPLOYEE SIGNATURE: _____ **DATE**: _____

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If you answered yes to any of the questions above, provide a detailed explanation to help the Licensed Health Care Professional evaluating your questionnaire determine your eligibility for wearing a respirator. Write down the questionnaire section number so the LHCP can understand your explanation. The questionnaire sections are numbered 1 through 15 with several related questions. Please make your explanation clear and legible.