KAISER PERMANENTE

Kaiser on the Job

www.kaisersantarosa.org/ohs
(707) 571-3485

Last Name: _____First _____MI_____

Kaiser Medical Record Number: _____

Employer: _____Department:_____

Job Title/Classification: _____

Cal/OSHA Respirator Medical Evaluation Questionnaire

To the employee: 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.

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

1. Today's date:_____ Last four digits of Social Security # _____
2. Maiden or former name:_____
3. Your age (to nearest year):_____ Date of Birth: _____
4. Sex (select one): ☐ Male ☐ Female
5. **Phone number(s) where you can be reached and you give permission for a health care professional who reviews this questionnaire to leave message(s) containing medical information**:
   a. M-F, 9-5 (_____) _____-_____ b. (_____) _____-_____

6. Your complete address: _____

---

7. **Check the type of respirator you will use (you can check more than one category):**
   - **a. ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).**
   - **b. ☐ Other type (for example, Half-or-Full face piece, powered-air purifying, supplied-air)**
   - **c. ☐ Self-contained breathing apparatus (SCBA).**

8. Have you worn a respirator previously? Yes☐ No☐ ?☐

   If yes, what type(s)? Choose from list above. _____

9. Please list chemicals/dust that respirator is to protect against: _____

   _____

10. Your height: _____ ft. _____in.

11. Your weight: _____ lbs.

12. Has your employer told you how to contact the health care professional who will review this questionnaire? **(707) 571-3678**, Kaiser Respirator Questionnaire Hotline Yes□ No□ ?□

Directions for Part A. Section 2. and Part B. of Cal/OSHA Respiratory Questionnaire

The following is an OSHA regulated history regarding your use, or potential use, of respiratory protection equipment. Please read all the questions carefully.

- **Explain any "Yes" answers next to the question or in the extra space on the last page (otherwise you may need an appointment to provide an explanation).**
- **Explain whether this is a current problem or is it resolved?**
- **Are you taking medications, undergoing testing, does it prevent you from using protective respiratory equipment? Or using (SCBA)?**

Feel free to attach another sheet if needed. Please note that a follow-up phone call, physical examination, or further testing, may be required based upon your answers.

Part A. Section 2. Every employee who has been selected to use any type of respirator must answer these questions.

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? **(Explain, give details, dates)**

a. Seizures (fits)?	Yes□ No□ ?□
b. Diabetes (Sugar disease)? **Name of Medications?**	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□ ?□
f. High cholesterol? **Name of Medications?**	Yes□ No□ ?□

3. **Have you ever** had any of the following pulmonary or lung problems? (**Explain "Yes**" and **Give Dates**)

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've been told about?	Yes□ No□ ?□

Diagnosis: _____Date:_____

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness? (**Explain" Yes**")

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 our 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? (**Explain "Yes**" **Give dates.**)

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 beats irregularly)? Yes☐ No☐ ?☐
g. High blood pressure? **Medications?**_____ Yes☐ No☐ ?☐
h. Any other heart problems that you've been told about? Yes☐ No☐ ?☐
Explain:_____
i. Family history of heart disease? Yes☐ No☐ ?☐
Who?_____**Diagnosis?**_____ **Age at diagnosis?**_____

6. **Have you ever** had any of the following cardiovascular or heart symptoms? (**Explain "Yes" and Give Dates)**

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 two 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?

a. Breathing or lung problems? Yes☐ No☐ ?☐
b. Heart trouble? Yes☐ No☐ ?☐
c. Blood pressure? Yes☐ No☐ ?☐
d. Seizures (fits)? Yes☐ No☐ ?☐
e. **Name of Medications for above problem(s):**
1._____
2. _____
3. _____

8. If you've **never** used a respirator, skip to question 9 and check this box: **No Respirator□.**
If you've used a respirator, have you ever had any of the following problems? **Please Describe.**

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. How often are you expected to use a respirator (respirators)?

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□ ?□

10. Work requiring respirator use is (mark all that apply) **Light □ Moderate □ Heavy □**

*Examples of **light** work are: sitting while writing, performing light assembly work, and controlling machines.*
*Examples of **moderate** work are: standing while nailing, transferring a moderate load (about 35 lbs.) at trunk level, and walking on a level surface about 2 mph.*
*Examples of **heavy** work are: lifting a heavy load (about 50 lbs) from the floor to your waist, shoveling, and standing while bricklaying.*

11. Do you normally have a beard, goatee, mustache, or other facial hair growth? Yes□ No□ ?□

12. How much exercise (outside of work) do you get in a typical week? Write "**NONE"** or describe.
What activity do you do? :_____
#day/wk_____ #minutes/day_____

13. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? Yes□ No□ ?□

PART B.:

****YOU CAN SKIP TO SIGNATURE SECTION IF YOU DO NOT WEAR FULL-FACE RESPIRATOR OR SCBA****

Questions 15 to 20 below must be answered by every employee who has been selected to use either a full-face piece 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.

15. **Have you ever** lost vision in either eye:

Temporarily? Yes□ No□ ?□
Permanently? Yes□ No□ ?□

16. Do you **currently** have any of the following vision problems?

a. Wear contact lenses? Yes□ No□ ?□
b. Wearing glasses? Yes□ No□ ?□
c. Color blind? Yes□ No□ ?□
d. Any other eye or vision problem? Yes□ No□ ?□

17. **Have you ever** had an injury to your ears, including a broken eardrum? Yes☐ No☐ ?☐

18. Do you **currently** have any of the following hearing problems?
    a. Difficulty hearing? Yes☐ No☐ ?☐
    b. Wearing a hearing aid? Yes☐ No☐ ?☐
    c. Any other hearing or ear problem? Yes☐ No☐ ?☐

19. **Have you ever** had a back injury? Date: _____ Treatment: _____
_____ Yes☐ No☐ ?☐

20. Do you **currently** have any of the following musculoskeletal problems? (**Explain "Yes"**)
    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 moving your head side to side? Yes☐ No☐ ?☐
    g. Difficulty bending at your knees? Yes☐ No☐ ?☐
    h. Difficulty squatting to the ground? Yes☐ No☐ ?☐
    j. Difficulty 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☐ ?☐

Please use this space to further explain any "Yes" answers.

Signature:_____Date:_____

Reviewed by:_____ Date:_____