Deaconess COMP CENTER

EFD Medical History Form

Name: _____

Date of Birth: _____

Today's Date: _____

HAVE YOU HAD ANY SURGERIES/OPERATIONS:

On Your Back, Arm, Leg or Knee?	Yes ☐	No ☐
To Treat a Hernia?	Yes ☐	No ☐
Varicose Veins?	Yes ☐	No ☐
Other Operations?	Yes ☐	No ☐
Have you Ever Been Hospitalized?	Yes ☐	No ☐

Describe any surgeries or hospitalizations:

ALLERGY - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE?

Serious Allergy?	Yes ☐	No ☐
Bad Reaction to Any Medication?	Yes ☐	No ☐
Advised Not to Take Any Medication (i.e. Aspirin)?	Yes ☐	No ☐

Describe any allergies:

SKIN - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:

Hives/Eczema or Rash?	Yes ☐	No ☐
Chronic Skin Problems (i.e. Cuts Slow to Heal)?	Yes ☐	No ☐
Excessive Skin Dryness?	Yes ☐	No ☐
Problems with "Easy Bruising"?	Yes ☐	No ☐
Chemical or Jewelry Rash/Sensitivity?	Yes ☐	No ☐

Describe skin issues/problems:

NEURO - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:

A Psychiatric or Emotional Problem?	Yes ☐	No ☐
Numbness/Weakness/Paralysis?	Yes ☐	No ☐
Dizziness or Fainting Spells?	Yes ☐	No ☐
Severe/Frequent or Migraine Headaches?	Yes ☐	No ☐
Head Injury, Concussion or Skull Fracture?	Yes ☐	No ☐
Neurological Disorders?	Yes ☐	No ☐
Seizures or Blackouts?	Yes ☐	No ☐
Stroke?	Yes ☐	No ☐

Describe any neurological issues:

EYES & EARS - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:

Hearing Loss?	**Yes** ☐	**No** ☐
Frequent Ear Infections?	**Yes** ☐	**No** ☐
Ringing in Ears?	**Yes** ☐	**No** ☐
Other Ear Problems?	**Yes** ☐	**No** ☐
Glaucoma or Cataracts?	**Yes** ☐	**No** ☐
Red Eyes?	**Yes** ☐	**No** ☐
Eye Injury/Vision Loss?	**Yes** ☐	**No** ☐
Other Eye Problems (i.e., Strain from VDT Use)?	**Yes** ☐	**No** ☐
Glasses/Contacts?	**Yes** ☐	**No** ☐

Date of last vision screen?

Describe any eye or ear problems:

HEAD/NECK - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:

Date of Last Dental Exam:

Recent Problems with Teeth Dentures?	**Yes** ☐	**No** ☐
Frequent Mouth Ulcers/Infections?	**Yes** ☐	**No** ☐
Sinus or Hay Fever?	**Yes** ☐	**No** ☐
Frequent Sore Throats?	**Yes** ☐	**No** ☐
Frequent Nose Bleeds?	**Yes** ☐	**No** ☐
Trouble with Thyroid (i.e., Taking Thyroid Medications)?	**Yes** ☐	**No** ☐
Problem Requiring Radiation Treatment to the Neck Area?	**Yes** ☐	**No** ☐

Describe any head/neck problems:

LUNGS - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:

Asthma or Wheezing?	**Yes** ☐	**No** ☐
Coughed up Blood?	**Yes** ☐	**No** ☐
Shortness of Breath without Apparent Reason?	**Yes** ☐	**No** ☐
TB or Positive Skin Test for TB	**Yes** ☐	**No** ☐
Pneumonia or Pleurisy?	**Yes** ☐	**No** ☐
Do You Cough Every Day, Especially in the Morning?	**Yes** ☐	**No** ☐
Pain or Tightness in Chest?	**Yes** ☐	**No** ☐
More than Three Episodes of Bronchitis in One Year?	**Yes** ☐	**No** ☐
Ever Smoked Tobacco in Any Form?	**Yes** ☐	**No** ☐

Date of last chest x-ray:

Describe any lung problems:

HEART - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:

Rheumatic Fever or Heart Murmur?	**Yes** ☐	**No** ☐
Heart Disease?	**Yes** ☐	**No** ☐
Treated for Heart Condition?	**Yes** ☐	**No** ☐
Unusually Cold or Bluish Colored Hands or Feet?	**Yes** ☐	**No** ☐
High Blood Pressure	**Yes** ☐	**No** ☐

If yes, how was your high blood pressure treated?

Do you Have a History of Elevated Cholesterol?	**Yes** ☐	**No** ☐
Anemia or Any Blood Disease?	**Yes** ☐	**No** ☐
Phlebitis, Varicose Veins, or Blood Clots/Poor Circulation?	**Yes** ☐	**No** ☐
Chest Pain with Activity?	**Yes** ☐	**No** ☐

Describe any heart or blood issues:

GI - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:

Ulcers?	**Yes** ☐	**No** ☐
Hiatal Hernia?	**Yes** ☐	**No** ☐
Indigestion, Pain or Unusual Burning in Stomach?	**Yes** ☐	**No** ☐
Vomiting of Blood?	**Yes** ☐	**No** ☐
Bloody/Tarry Bowel Movements?	**Yes** ☐	**No** ☐
Colitis or Nervous Stomach?	**Yes** ☐	**No** ☐
Yellow Jaundice or Hepatitis?	**Yes** ☐	**No** ☐
Problems with Your Pancreas?	**Yes** ☐	**No** ☐
Gallbladder Disease?	**Yes** ☐	**No** ☐

Describe any gastrointestinal isssues:

KIDNEYS - HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:

Bladder or Kidney Infections?	**Yes** ☐	**No** ☐
Kidney Stones?	**Yes** ☐	**No** ☐
Burning or Discomfort on Urination or Frequent Urination?	**Yes** ☐	**No** ☐
Hernia?	**Yes** ☐	**No** ☐
Blood in Urine?	**Yes** ☐	**No** ☐

Describe any kidney problems:

MISCELLANEOUS - HAVE YOU HAD OR DO YOU CURRENTLY HAVE:

Diabetes or Sugar in Your Blood or Urine?	**Yes** ☐	**No** ☐
Cancer of Any Kind?	**Yes** ☐	**No** ☐

Describe any problems indicated above:

MUSCLE SKELETAL - HAVE YOU HAD OR DO YOU CURRENTLY HAVE?

Arthritis, Rheumatism, Neck, back or Spine Injury or Disease?	**Yes** ☐	**No** ☐
Been Treated for a Back Problem?	**Yes** ☐	**No** ☐
Recurrent Stiffness or Back Pain?	**Yes** ☐	**No** ☐
Bursitis, Tendonitis?	**Yes** ☐	**No** ☐
Recurrent Pulled Muscles or Sprains?	**Yes** ☐	**No** ☐
Hand or Wrist Injury or Problems?	**Yes** ☐	**No** ☐
Hip or Knee Injury or Problem?	**Yes** ☐	**No** ☐
Ankle or Foot Injury or Problem?	**Yes** ☐	**No** ☐
Frostbite?	**Yes** ☐	**No** ☐
Job Requiring Heavy Lifting, Standing or Sitting for Long Periods?	**Yes** ☐	**No** ☐
Any Broken Bones?	**Yes** ☐	**No** ☐

Describe any muscle/skeletal problems:

FOR FEMALES ONLY - HAVE YOU HAD OR DO YOU CURRENTLY HAVE:

Menstrual Irregularities?	**Yes** ☐	**No** ☐
Recurrent Problems of the Female Organs?	**Yes** ☐	**No** ☐
Breast Masses or Lumps?	**Yes** ☐	**No** ☐
Do You Practice Monthly Breast Self Exam?	**Yes** ☐	**No** ☐
Have You Ever Had a Mammogram?	**Yes** ☐	**No** ☐

Date of Last Pap Smear:

Describe any problems indicated in this section:

FOR MALES ONLY - HAVE YOU HAD OR DO YOU CURRENTLY HAVE:

Prostate or Testicular Problems?	**Yes** ☐	**No** ☐
Breast Tenderness, Swelling or Lumps?	**Yes** ☐	**No** ☐
Do You Practice Monthly Testicular Self Exam?	**Yes** ☐	**No** ☐

Describe any problems indicated in this section:

GENERAL LIFESTYLE I - Check the Answer That Best Describes You

General Health	Poor ☐	Fair ☐	Good ☐	Excellent ☐
% of Seatbelt Use	0-24% ☐	25-49% ☐	50-74% ☐	75-100% ☐
Daily Stress	Low ☐	Moderate ☐	High ☐	
Average Hours of Sleep	< 7 hrs ☐	7-8 hrs ☐	> 8 hrs ☐	
Average Meals Daily	1 meal ☐	2 meals ☐	3 or more ☐	
Number of Eggs per Week	0-1 eggs ☐	2 eggs ☐	3 or more ☐	
Average Number Red Meat Meal Per Week	0-1 meal ☐	2 meals ☐	3 or more ☐	
Average Number of Alcohol Beverages/Beers Per Week	0-5 ☐	6 to 14 ☐	15 or more ☐	
Do You Exercise 3 Times Per Week, 30-40 Minutes Each Time?	**Yes** ☐	**No** ☐		

Identify Types of Exercises:

Are You More Than 30% Above Your Ideal Weight?	**Yes** ☐	**No** ☐
Have You Received a Tetanus Booster in the Last 10 Years?	**Yes** ☐	**No** ☐
Do You Take Any Prescription Medication?	**Yes** ☐	**No** ☐

List any prescription medications you take:

Do You Take Nonprescription Medication (or Over the Counter Drugs) on a Regular Basis?	**Yes** ☐	**No** ☐

List any non-prescription meds you take regularly:

Please describe any problems indicated in this section:

GENERAL LIFESTYLE II

Do You Participate in a Workplace Wellness Help Promotion Program?	**Yes** ☐	**No** ☐
Which of the following would you participate in if offered?		
Cholesterol Screen	**Yes** ☐	**No** ☐
Blood Pressure Screen	**Yes** ☐	**No** ☐
Weight Loss	**Yes** ☐	**No** ☐
Nutrition Program	**Yes** ☐	**No** ☐
Stress Management	**Yes** ☐	**No** ☐
Smoking Cessation	**Yes** ☐	**No** ☐
CPR Classes	**Yes** ☐	**No** ☐
Blood Drive	**Yes** ☐	**No** ☐
Health Risk Appraisal	**Yes** ☐	**No** ☐
Self-Directed Exercise	**Yes** ☐	**No** ☐
Health Education Program	**Yes** ☐	**No** ☐
Women's Health	**Yes** ☐	**No** ☐

Please describe any other programs in which you would like the opportunity to particpate:

WORK HISTORY I - HAVE YOU EVER:

Been Restricted in Your Work or Given "Light Duty" Because of Your Health or Injury?	**Yes** ☐	**No** ☐
Left a Job Because of Health Problems?	**Yes** ☐	**No** ☐
Been Injured on the Job and Treated by a Doctor?	**Yes** ☐	**No** ☐
Received Compensation for an Industrial Injury or Illness?	**Yes** ☐	**No** ☐
Are You Receiving Any Health Care Treatment (i.e., Physician Therapy, Chiropractic, Acupuncture, Medical, etc.)?	**Yes** ☐	**No** ☐
Been Hospitalized in the Last Five Years?	**Yes** ☐	**No** ☐
Had Any Illness or Injury That We Have Not Asked You About?	**Yes** ☐	**No** ☐

Describe any situations you indicated in this section:

WORK HISTORY II

Do You Have Hobbies Such as Furniture Refinishing, Painting, Hunting, Shooting or Model Building?	**Yes** ☐	**No** ☐
Do You Moonlight or have a Second Job?	**Yes** ☐	**No** ☐

Describe any situations you indicated in this section:

WORK HISTORY III - EXPOSURES - HAVE YOU EVER WORKED AROUND A:

Chemical Plant?	**Yes** ☐	**No** ☐
Coke Oven?	**Yes** ☐	**No** ☐
Construction?	**Yes** ☐	**No** ☐
Cotton, Flax or Hemp Mill?	**Yes** ☐	**No** ☐
Electronics Plant?	**Yes** ☐	**No** ☐
Farm?	**Yes** ☐	**No** ☐
Foundry?	**Yes** ☐	**No** ☐
Hazardous Waste Industry?	**Yes** ☐	**No** ☐
Hospital?	**Yes** ☐	**No** ☐
Lumber Mill?	**Yes** ☐	**No** ☐

Metal Production?	**Yes** ☐	**No** ☐
Mine?	**Yes** ☐	**No** ☐
Nuclear Industry?	**Yes** ☐	**No** ☐
Paper Mill?	**Yes** ☐	**No** ☐
Pottery Mill?	**Yes** ☐	**No** ☐
Refinery?	**Yes** ☐	**No** ☐
Rubber Processing Plant?	**Yes** ☐	**No** ☐
Sand Pit or Quarry?	**Yes** ☐	**No** ☐
Service Station?	**Yes** ☐	**No** ☐
Shipyard?	**Yes** ☐	**No** ☐
Smelter?	**Yes** ☐	**No** ☐

HAVE YOU EVER BEEN EXPOSED TO:

Aldrin?	**Yes** ☐	**No** ☐
Arsenic?	**Yes** ☐	**No** ☐
Asbestos?	**Yes** ☐	**No** ☐
Benzene?	**Yes** ☐	**No** ☐
Benzidine?	**Yes** ☐	**No** ☐
Beryllium?	**Yes** ☐	**No** ☐
BIS Chlormethyl Ether?	**Yes** ☐	**No** ☐
Cadmium?	**Yes** ☐	**No** ☐
Carbon Disulfide?	**Yes** ☐	**No** ☐
Carbon Tetrachloride?	**Yes** ☐	**No** ☐
Chlorine?	**Yes** ☐	**No** ☐
Chloradane?	**Yes** ☐	**No** ☐
Chloroform?	**Yes** ☐	**No** ☐
Chloroprene?	**Yes** ☐	**No** ☐
Chromates?	**Yes** ☐	**No** ☐
Chromic Acid Mist?	**Yes** ☐	**No** ☐
Cutting Oils?	**Yes** ☐	**No** ☐
DDT?	**Yes** ☐	**No** ☐
Dieldrin?	**Yes** ☐	**No** ☐
Doixin?	**Yes** ☐	**No** ☐
Dust, Coal?	**Yes** ☐	**No** ☐
Dust, Sandblasting?	**Yes** ☐	**No** ☐
Dust, Other?	**Yes** ☐	**No** ☐
Ethyl Dibromide?	**Yes** ☐	**No** ☐
Ehylene Oxide?	**Yes** ☐	**No** ☐
Extreme Cold or Heat?	**Yes** ☐	**No** ☐
Heptachlor?	**Yes** ☐	**No** ☐
Hexachlorobenzene?	**Yes** ☐	**No** ☐
Isocyanates (TDI, MDI)?	**Yes** ☐	**No** ☐
Loud or Continuous Noise?	**Yes** ☐	**No** ☐
Mercury?	**Yes** ☐	**No** ☐
Methylene Chloride?	**Yes** ☐	**No** ☐
Nickel?	**Yes** ☐	**No** ☐
PCBs?	**Yes** ☐	**No** ☐
Pesticides, Herbicides?	**Yes** ☐	**No** ☐
Phenois?	**Yes** ☐	**No** ☐
Phosgene?	**Yes** ☐	**No** ☐
Plastics?	**Yes** ☐	**No** ☐
Radioactive Materials?	**Yes** ☐	**No** ☐
Roofing Materials?	**Yes** ☐	**No** ☐
Rubber?	**Yes** ☐	**No** ☐
Silica?	**Yes** ☐	**No** ☐
Solvents/Degreasers?	**Yes** ☐	**No** ☐

Soots and Tars?	**Yes** ☐	**No** ☐
Spray Painting?	**Yes** ☐	**No** ☐
TRI/PER Chloroethylene?	**Yes** ☐	**No** ☐
Vinyl Chloride?	**Yes** ☐	**No** ☐

List Any Toxins/Chemicals/Biological Hazards You Might Currently Be Exposed to:

Describe any exposures you indicated in this section:

WORK HISTORY IV - JOBS

In the space below, starting with the most recent, describe the jobs you've held, including dates year-to-year, company, position, and any work hazards

CONFIRMATION

I certify that the above information is complete to the best of my knowledge. I hereby give permission to release work related information to the proper authorities of my employer: **Yes** ☐ **No** ☐

Deaconess COMP Center
329 West Columbia
Evansville, IN 47710
450-7455

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

Can you read (check one): **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

Company Name: _____

Department# _____ **Employee ID#** _____

1. Today's date: _____

2. Your Name: _____

3. Your Birthdate: _____

4. Sex: (check 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: _____

9. The best time to reach you at this number: _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire: (check one): **Yes** ☐ **No** ☐

11. 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 type, powered air purifying, supplied air, self-contained breathing apparatus.

12. Have you worn a respirator? (check one): **Yes** ☐ **No** ☐

If "yes" what type(s): _____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please check "yes" or "no").

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month: **Yes** ☐ **No** ☐
   If you answered "yes" to the question above - state number of years ☐

2. Have you **ever had** any of the following conditions?

1. Seizures (fits):	**Yes** ☐	**No** ☐
2. Diabetes (sugar disease):	**Yes** ☐	**No** ☐
3. Allergic reactions that interfere with your breathing:	**Yes** ☐	**No** ☐
4. Claustrophobia (fear of closed-in places):	**Yes** ☐	**No** ☐
5. Trouble smelling odors:	**Yes** ☐	**No** ☐

COMMENTS:

3. Have you **ever had** any of the following pulmonary or lung problems?

1. Asbestosis:	**Yes** ☐	**No** ☐
2. Asthma:	**Yes** ☐	**No** ☐
3. Chronic bronchitis:	**Yes** ☐	**No** ☐
4. Emphysema:	**Yes** ☐	**No** ☐
5. Pneumonia:	**Yes** ☐	**No** ☐
6. Tuberculosis:	**Yes** ☐	**No** ☐
7. Silicosis:	**Yes** ☐	**No** ☐
8. Pneumothorax (collapsed lung):	**Yes** ☐	**No** ☐
9. Lung Cancer:	**Yes** ☐	**No** ☐
10. Broken rib:	**Yes** ☐	**No** ☐
11. Any chest injuries or surgeries:	**Yes** ☐	**No** ☐
12. Any other lung problem that you've been told about:	**Yes** ☐	**No** ☐

COMMENTS:

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

1. Shortness of breath:	**Yes** ☐	**No** ☐
2. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	**Yes** ☐	**No** ☐
3. Shortness of breath when walking with other people at ordinary pace on level ground:	**Yes** ☐	**No** ☐
4. Have to stop for breath when walking at your own pace on level ground:	**Yes** ☐	**No** ☐
5. Shortness of breath when washing or dressing yourself:	**Yes** ☐	**No** ☐
6. Shortness of breath that interferes with your job:	**Yes** ☐	**No** ☐
7. Coughing that produces phlegm (thick sputum):	**Yes** ☐	**No** ☐
8. Coughing that wakes you early in morning:	**Yes** ☐	**No** ☐
9. Coughing that occurs mostly when you are lying down:	**Yes** ☐	**No** ☐
10. Coughing up blood in the last month:	**Yes** ☐	**No** ☐
11. Wheezing:	**Yes** ☐	**No** ☐
12. Wheezing that interferes with your job:	**Yes** ☐	**No** ☐
13. Chest pain when you breath deeply:	**Yes** ☐	**No** ☐
14. Any other symptoms that you think may be related to lung problems:	**Yes** ☐	**No** ☐

COMMENTS:

5. Have you **ever had** any of the following cardiovascular or heart problems?

1. Heart attack:	**Yes** ☐	**No** ☐
2. Stroke:	**Yes** ☐	**No** ☐
3. Angina:	**Yes** ☐	**No** ☐

4. Heart failure:	**Yes** ☐	**No** ☐
5. Swelling in your legs or feet (not caused by walking):	**Yes** ☐	**No** ☐
6. Heart arrhythmia (heart beating irregularly):	**Yes** ☐	**No** ☐
7. High blood pressure:	**Yes** ☐	**No** ☐
8. Any other heart problem that you've been told about:	**Yes** ☐	**No** ☐

COMMENTS:

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

1. Frequent pain or tightness in your chest:	**Yes** ☐	**No** ☐
2. Pain or tightness in your chest during physical activity:	**Yes** ☐	**No** ☐
3. Pain or tightness in your chest that interferes with your job:	**Yes** ☐	**No** ☐
4. In the past two years, have you noticed your heart skipping or missing a beat:	**Yes** ☐	**No** ☐
5. Heartburn or indigestion that is not related to eating:	**Yes** ☐	**No** ☐
6. Any other symptoms that you think may be related to heart or circulation problems:	**Yes** ☐	**No** ☐

COMMENTS:

7. Do you **currently** take medication for any of the following problems?

1. Breathing or lung problems:	**Yes** ☐	**No** ☐
2. Heart trouble:	**Yes** ☐	**No** ☐
3. Blood pressure:	**Yes** ☐	**No** ☐
4. Seizures (fits):	**Yes** ☐	**No** ☐

COMMENTS:

8. If you've used a respirator, have you **ever had** any of the following problems?

1. Eye irritation:	**Yes** ☐	**No** ☐
2. Skin allergies or rashes:	**Yes** ☐	**No** ☐
3. Anxiety:	**Yes** ☐	**No** ☐
4. General weakness or fatigue:	**Yes** ☐	**No** ☐
5. Any other problem that interferes with your use of a respirator:	**Yes** ☐	**No** ☐

COMMENTS:

9. Would you like to talk to a health care professional who will review this questionnaire about your answers to the questionnaire: **Yes** ☐ **No** ☐

Questions 10 to 15 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).

10. Have you **ever lost** vision in either eye (temporarily or permanently):	**Yes** ☐	**No** ☐

COMMENTS:

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

1. Wear contact lenses:	**Yes** ☐	**No** ☐
2. Wear glasses:	**Yes** ☐	**No** ☐
3. Color blind:	**Yes** ☐	**No** ☐
4. Any other eye or vision problem:	**Yes** ☐	**No** ☐

COMMENTS:

12. Have you **ever had** an injury to your ears, including a broken ear drum:	**Yes** ☐	**No** ☐

COMMENTS:

13. Do you **currently** have any of the following hearing problems?

1. Difficulty hearing:	**Yes** ☐	**No** ☐
2. Wear a hearing aid:	**Yes** ☐	**No** ☐
3. Any other hearing or ear problem:	**Yes** ☐	**No** ☐

COMMENTS:

14. Have you **ever had** a back injury:	**Yes** ☐	**No** ☐

COMMENTS:

15. Do you **currently** have any of the following musculoskeletal problems?

1. Weakness in any of your arms, hands, legs, or feet:	**Yes** ☐	**No** ☐
2. Back pain:	**Yes** ☐	**No** ☐
3. Difficulty fully moving your arms and legs:	**Yes** ☐	**No** ☐
4. Pain or stiffness when you lean forward or backward at the waist:	**Yes** ☐	**No** ☐
5. Difficulty fully moving your head up or down:	**Yes** ☐	**No** ☐
6. Difficulty fully moving your head side to side:	**Yes** ☐	**No** ☐
7. Difficulty bending at your knees:	**Yes** ☐	**No** ☐
8. Difficulty squatting to the ground:	**Yes** ☐	**No** ☐
9. Climbing a flight of stairs or a ladder carrying more than 25 lbs:	**Yes** ☐	**No** ☐
10. Any other muscle or skeletal problem that interferes with using a respirator:	**Yes** ☐	**No** ☐

COMMENTS:

Part B. Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

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're working under these conditions: **Yes** ☐ **No** ☐

2. 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 below 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 (e.g., in sandblasting):	**Yes** ☐	**No** ☐
c. Tungsten/cobalt (e.g., 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 reasons (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. Will you be using any of the following items with your 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 200kcal per hour):	**Yes** ☐	**No** ☐

If "yes" how long does this period last during the average shift: ☐ hrs. ☐ mins.

Examples of light work effort are **sitting** while writing, typing, drafting, or performing light assembly work; or **standing** while operating a drill press (1-3lbs.) 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're 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 deg. F): **Yes** ☐ **No** ☐

15. Will you be working under humid conditions: **Yes** ☐ **No** ☐

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

17. Describe below any special or hazardous conditions you might encounter when you're 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'll be exposed to when you're using your respirator(s):

a) Name of the first toxic substance and estimated maximum exposure level per shift:

b) Name of the second toxic substance and estimated maximum exposure level per shift:

c) Name of the third toxic substance and estimated maximum exposure level per shift:

d) The name of any other toxic substances that you'll be exposed to while using your respirator:

19. 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):

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