ASCENSION MEDICAL CLINIC
Occupational and Preventive Medicine

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To the employer: Answers to questions in Section 1, and to question 9 in section 2 of Part A, do not require a medical examination.

To the employee: Can you read? (Circle 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. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (PLEASE PRINT).

1. Your Name _____ 2. Age _____ 3. SSN _____

4. Sex (circle one) Male Female 5. Your height _____ 6. Your weight _____

7. Your job title: _____

8. A phone number where you can be reached by the healthcare professional who will review this questionnaire:
(Include Area Code): _____ Best Time To Reach You _____

9. Has your employer told you how to contact the health care professional who will review this questionnaire?
(Circle one): YES NO

10. Check the type of respirator you will use (you can check more than one):
A. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
B. _____ Other type (for example, half or full face piece type, powdered air purifying, supplied air, self contained breathing apparatus).

11. Have you ever worn a respirator? YES NO
If yes, what type(s): _____

Part A Section 2. (Mandatory) PLEASE PRINT

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? (Circle one) YES NO
If yes, How many cigarettes per day? _____ How many years? _____
If no, Have you smoked tobacco in the past? (Circle one) YES NO
If yes, how long ago did you quit smoking?_____ How much were you smoking before you quit?_____

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

YES	NO	Seizures (fits)	YES	NO	Claustrophobia (fear of closed-in places)
YES	NO	Diabetes (sugar disease)	YES	NO	Trouble smelling odors
YES	NO	Allergic reaction that interferes with your breathing			

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

YES	NO	Asbestosis	YES	NO	Asthma
YES	NO	Chronic Bronchitis	YES	NO	Emphysema
YES	NO	Pneumonia	YES	NO	Tuberculosis
YES	NO	Silicosis	YES	NO	Pneumothorax
YES	NO	Lung Cancer	YES	NO	Broken Ribs
YES	NO	Any chest injuries or surgeries	YES	NO	Any other lung problems

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

YES	NO	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 fast 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

If yes, Explain: _____

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 problems that you've been told about
YES	NO	i. Frequent pain or tightness in your chest
YES	NO	j. Pain and tightness in your chest during physical activity
YES	NO	k. Pain or tightness in your chest that interferes with your job
YES	NO	l. In the past two years, have you noticed your heart skipping or missing a beat?
YES	NO	m. Heartburn or indigestion that is not related to eating
YES	NO	n. Any symptoms that you think may be related to heart or circulation problems

6. 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
YES	NO	e. Diabetes

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

YES	NO	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 problems that interfere with your use of a respirator

8. Would you like to talk with the health care professional who will review the answers in your questionnaire? YES NO

Questions 9-14 below must be answered by every employee who has been selected to use either a full-face piece respirator or a (SCBA). For Employees who have been selected to use other types of respirators, answering these questions is voluntary.

9. Have you ever lost vision in either eye (temporarily or permanently)? YES NO

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

YES	NO	a. Wear contact lenses	YES	NO	b. Wear glasses
YES	NO	c. Color blind	YES	NO	d. Any other eye or vision problems

11. Have you ever had an injury to your ears, including a broken eardrum? YES NO

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

YES	NO	a. Difficulty hearing
YES	NO	b. Wear a hearing aid
YES	NO	c. Any other hearing or ear problems

13. Have you ever had a back injury? YES NO

14. Do you currently have any of the following musculosketal problems?

YES NO 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

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 this questionnaire.

1. In your present job, are you working at high altitudes (over 5000 feet) or in a place that has lower than normal amounts of oxygen?
   YES NO
2. If yes to the above question, do you have feeling of dizziness, shortness of breath, pounding in your chest or other symptoms when you're working under these conditions?
   YES NO
3. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g. gasses, fumes, or dust), or have you come into skin contact with hazardous chemicals?
   YES NO
   If yes, name the chemicals if you know them _____
   _____

4. Have you ever worked with any of the materials, or under any of the conditions listed below?

YES	NO	a. Asbestos	YES	NO	b. Silica (e.g. sandblasting)	YES	NO	c. Tungsten/Cobalt
YES	NO	d. Beryllium	YES	NO	e. Aluminum	YES	NO	f. Coal (mining)
YES	NO	g. Iron	YES	NO	h. Tin	YES	NO	i. Dusty environments
			YES	NO	j. Any other hazardous exposures.			

5. List any second jobs or side businesses you have: _____
   _____

6. List your previous occupations: _____
   _____
   _____

7. List your current and previous hobbies: _____
   _____

8. Have you ever been in the military services? YES NO
   If yes, were you exposed to biological or chemical agents (either in training or combat)?

9. Have you ever worked on a HAZMAT team? YES NO

10. 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: _____
    _____
    _____

11. Will you be using any of the following items with you respirator?

YES NO a. HEPA filters YES NO b. Canisters (gas masks) YES NO c. Cartridges

12. How often are you expected to wear a respirator?

YES NO a. Escape only (no rescue) YES NO b. Emergency rescue only YES NO c. Less than 5 hrs per wk
YES NO d. Less than 2 hrs per day YES NO e. 2 to 4 hrs per day YES NO f. Over 4 hrs per day

13. During the period you are using the respirator(s), is your work effort:

YES NO A. Light (less than 200 kcal per hour).

If "yes", how long does this period last during the average shift: _____hours _____minutes.

Examples of a light work effort are sitting while typing, writing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs) or controlling machines.

YES NO B. Moderate (200-350 kcal per hour).

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, performing assembly work, or transferring a moderate load (about35lbs) at truck 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 100lbs) on a level surface.

YES NO C. Heavy (above 350 kcal per hour).

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

14. Will you be wearing protective clothing and/or equipment when you're using your respirator? YES NO

If yes describe this protective clothing and/or equipment? _____

_____

15. Will you be working under hot conditions (temp. exceeding 77 degree F)? YES NO
16. Will you be working under humid conditions? YES NO
17. Describe the work you will be doing while using your respirator._____ _____

_____

18. Describe any special or hazardous conditions you might encounter when using your respirator._____ _____

_____

19. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when using your respirator:

1st toxic substance: _____
Estimated exposure level per shift_____
Duration of exposure per shift_____

2nd toxic substance: _____
Estimated exposure level per shift_____
Duration of exposure per shift_____

3rd toxic substance: _____
Estimated exposure level per shift_____
Duration of exposure per shift_____

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

_____

20. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well being of others (i.e., rescue and security)._____ _____

_____

_____ _____ _____ _____

Patients Signature Date Physicians Signature Date

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish. I acknowledge that I have been given an opportunity to read this office's Notice of Privacy Practices.

_____ _____ _____

Please Print Your Name Please Sign Your Name Date