

Return to: Employee Health Services UCT 1620  
Attention: Susan Parnell or Cindy Crosson  
Or Fax to: 713/500-3263

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## **Appendix C – Medical Questionnaire**

### Medical Questionnaire for Respiratory Protection

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.**

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## Medical Questionnaire for Respiratory Protection

### Part A. Section I. (Mandatory)

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

Employee ID: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: Male / Female

Height: \_\_\_\_\_ ft \_\_\_\_\_ inch Weight: \_\_\_\_\_ lbs

Company: \_\_\_\_\_ Location: \_\_\_\_\_

Department: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Job Title/Occupation: \_\_\_\_\_

A phone number where you can be reached by the health care professional who reviews this questionnaire (include area code) ( ) \_\_\_\_\_

The best time to phone you at this number: \_\_\_\_\_

1. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one) **YES** **NO**
2. 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)

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b. \_\_\_\_\_ Other type: Circle type(s): Half or Full Face Piece, Powered air-purifying, Self-contained breathing apparatus (SCBA).

3. Have you ever worn a respirator? (circle one):      **YES**      **NO**

If "Yes", what type(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Part A. Section II. (Mandatory)

Questions 1 through 9 **must be answered by every employee who has been selected to use any type of respirator.** (Please circle "YES" or "NO" or check the appropriate box):

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?

Condition	Had in past	Have at Present	Never had
Seizures (fits)			
Diabetes (sugar disease)			
Allergic reactions that interfere with your breathing			
Claustrophobia (fear of closed-in Places)			
Trouble smelling odors			

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

Condition	Had in past	Have at Present	Never had
Asbestosis			
Asthma			
Chronic bronchitis			
Emphysema.			
Pneumonia			
Tuberculosis			
Silicosis			
Pneumothorax (collapsed lung)			
Lung cancer			
Broken ribs			
Any chest injuries or surgeries			
Any other lung problems that you've been told about Explain:			

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

Condition	Yes	No
Shortness of breath		
Shortness of breath when walking fast on level ground or walking up a slight hill or incline		
Shortness of breath when 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 walking or dressing yourself		
Shortness of breath that interferes with your job		
Coughing that produces phlegm (thick sputum)		
Coughing that wakes you early in the morning		
Coughing that occurs mostly when you are lying down		
Coughing up blood in the last month		
Wheezing		
Wheezing that interferes with your job		
Chest pain when you breathe deeply		
Any other symptoms that you think may be related to lung problems? Explain:		

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

Condition	Had in past	Have at Present	Never had
Heart Attack			
Stroke			
Angina			
Heart Failure			
Swelling in your legs or feet (not caused by walking)			
Heart arrhythmia (heart beating irregularly)			
High blood pressure			
Any other heart problem that you've been told about? Explain:			

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

Condition	Had in past	Have at Present	Never had
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 your job			
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 symptoms that you think may be related to heart or circulation problems? Explain:			

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

Condition	Yes	No
Breathing or lung problem		
Heart trouble		
Blood pressure		
Seizures (fits)		

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8. If you've used a respirator, have you *ever had* any of the following problems?  
(If you've never used a respirator go to question 9):

Condition	Yes	No
Eye irritation		
Skin allergies or rashes		
Anxiety		
General weakness or fatigue		
Any other problem that interferes with your use of a respirator? Explain:		

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire:                   **YES**                    **NO**

10. Have you *ever lost* vision in either eye (temporarily or permanently) **YES**                    **NO**  
If yes, was vision loss permanent?    **YES**                    **NO**

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

Condition	Yes	No
Wear contact lenses		
Wear glasses		
Color blind		
Any other eye or vision problem Explain:		

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

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

Condition	Yes	No
Difficulty Hearing		
Wear a hearing aid		
Any other hearing or ear problems? Explain:		

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14. Have you *ever had* a back injury? **YES** **NO**

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

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

**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 are 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 if you know them: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Condition	Yes	No
Asbestos		
Silica (e.g. in sandblasting)		
Tungsten/cobalt (e.g. grinding or welding this material)		
Beryllium		
Aluminum		
Coal (for example, mining)		
Iron		
Tin		
Dusty environments		
Any other hazardous exposures? If yes, explain 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 ever been in the military service?           **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)?            **YES**            **NO**

If "yes", name the medications if you know them: \_\_\_\_\_  
\_\_\_\_\_

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10. Will you be using any of the following items with your respirator(s)?

Item	Yes	No
HEPA Filters		
Canisters (for example, gas masks)		
Cartridges		

11. How often are you expected to use the respirator(s):

Situation	Yes	No
Escape only (no rescue)		
Emergency rescue only		
Less than 5 hours per week		
Less than 2 hours per day		
2 to 4 hours per day		
Over 4 hours per day		

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 a 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 a heavy work effort 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 to an 8 degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs).

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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 (temperatures exceeding 77°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 any special or hazardous conditions you might encounter when you're using your respirator(s) for example, confines spaces, life-threatening gases: \_\_\_\_\_  
\_\_\_\_\_

18. Provide the following information, if you know it, for each of the toxic substances that you'll be exposed to when you're using your respirator(s):

Name of Toxic Substance	Estimated maximal exposure level per shift	Duration of exposure per shift
1.		
2.		
3.		
4.		
5.		

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): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_