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INITIAL MEDICAL QUESTIONNAIRE
CONFIDENTIAL MEDICAL INFORMATION

SECTION 1 (EMPLOYEE)				MRN:	
				TODAY'S DATE:	
1.	NAME:	LAST	FIRST	MIDDLE	
2.	YOUR DATE OF BIRTH:		3. SEX:	☐ MALE ☐ FEMALE	
4.	YOUR HEIGHT:	FT. IN.	5. YOUR WEIGHT:	LBS.	
6.	DEPARTMENT/PROGRAM NAME:				
7.	DEPARTMENT NUMBER:		8. YOUR JOB TITLE:		
9.	EMAIL ADDRESS:				
10.	A PHONE NUMBER WHERE YOU CAN BE REACHED BY THE HEALTH CARE PROFESSIONAL WHO REVIEWS THIS QUESTIONNAIRE (INCLUDE THE AREA CODE):				
10.A.	THE BEST TIME TO PHONE YOU AT THIS NUMBER?				
11.	WORK/CELL PHONE NUMBER:				

		YES	NO
12.	HAS YOUR EMPLOYER TOLD YOU HOW TO CONTACT THE HEALTH CARE PROFESSIONAL WHO WILL REVIEW THIS QUESTIONNAIRE? (EMPLOYEE HEALTH)	☐	☐
13.	CHECK THE TYPE OF RESPIRATOR YOU WILL USE (YOU CAN CHECK MORE THAN ONE):		
	1. N, R, OR P DISPOSABLE RESPIRATOR (FILTER-MASK, NON- CARTRIDGE TYPE ONLY).		☐
	2. OTHER TYPE (FOR EXAMPLE, HALF- OR FULL-FACE PIECE TYPE, POWERED-AIR PURIFYING, SUPPLIED-AIR, SELF-CONTAINED BREATHING APPARATUS).		☐
14.	HAVE YOU WORN A RESPIRATOR: IF "YES", WHAT TYPE(S):	☐	☐

SECTION 2 **NOTE: ANY 'YES' ANSWERS IN SECTION 2 Q4 OR Q5, PERFORM A PEAK FLOW TEST**

		YES	NO
1.	CAN YOU READ?	☐	☐
2.	DO YOU CURRENTLY SMOKE TOBACCO, OR HAVE YOU SMOKED TOBACCO IN THE LAST MONTH?	☐	☐
3.	HAVE YOU **EVER HAD** ANY OF THE FOLLOWING CONDITIONS?	YES	NO
	a. SEIZURES (FITS):	☐	☐
	b. DIABETES (SUGAR DISEASE):	☐	☐
	c. ALLERGIC REACTIONS THAT INTERFERE WITH YOUR BREATHING:	☐	☐
	d. CLAUSTROPHOBIA (FEAR OF CLOSED-IN PLACES):	☐	☐
	e. TROUBLE SMELLING ODORS:	☐	☐
4.	HAVE YOU **EVER HAD** ANY OF THE FOLLOWING PULMONARY OR LUNG PROBLEMS?	YES	NO
	a. ASBESTOSIS:	☐	☐
	b. ASTHMA:	☐	☐

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4. HAVE YOU **EVER HAD** ANY OF THE FOLLOWING PULMONARY OR LUNG PROBLEMS? (CONTINUED)		YES	NO
	c. CHRONIC BRONCHITIS:	☐	☐
	d. EMPHYSEMA:	☐	☐
	e. PNEUMONIA:	☐	☐
	f. TUBERCULOSIS:	☐	☐
	g. SILICOSIS:	☐	☐
	h. PNEUMOTHORAX (COLLAPSED LUNG):	☐	☐
	i. LUNG CANCER:	☐	☐
	j. BROKEN RIBS:	☐	☐
	k. ANY CHEST INJURIES OR SURGERIES:	☐	☐
	l. ANY OTHER LUNG PROBLEM THAT YOU'VE BEEN TOLD ABOUT:	☐	☐
5. DO YOU **CURRENTLY** HAVE ANY OF THE FOLLOWING SYMPTOMS OF PULMONARY OR LUNG ILLNESS?		YES	NO
	a. SHORTNESS OF BREATH:	☐	☐
	b. SHORTNESS OF BREATH WHEN WALKING FAST ON LEVEL GROUND OR WALKING UP A SLIGHT HILL OR INCLINE:	☐	☐
	c. SHORTNESS OF BREATH WHEN WALKING WITH OTHER PEOPLE AT AN ORDINARY PACE ON LEVEL GROUND:	☐	☐
	d. HAVE TO STOP FOR BREATH WHEN WALKING AT YOUR OWN PACE ON LEVEL GROUND:	☐	☐
	e. SHORTNESS OF BREATH WHEN WASHING OR DRESSING YOURSELF:	☐	☐
	f. SHORTNESS OF BREATH THAT INTERFERES WITH YOUR JOB:	☐	☐
	g. COUGHING THAT PRODUCES PHLEGM (THICK SPUTUM):	☐	☐
	h. COUGHING THAT WAKES YOU EARLY IN THE MORNING:	☐	☐
	i. COUGHING THAT OCCURS MOSTLY WHEN YOU ARE LYING DOWN:	☐	☐
	j. COUGHING UP BLOOD IN THE LAST MONTH:	☐	☐
	k. WHEEZING:	☐	☐
	l. WHEEZING THAT INTERFERES WITH YOUR JOB:	☐	☐
	m. CHEST PAIN WHEN YOU BREATHE DEEPLY:	☐	☐
	n. ANY OTHER SYMPTOMS THAT YOU THINK MAY BE RELATED TO LUNG PROBLEMS:	☐	☐
6. HAVE YOU **EVER HAD** ANY OF THE FOLLOWING CARDIOVASCULAR OR HEART PROBLEMS?		YES	NO
	a. HEART ATTACK:	☐	☐
	b. STROKE:	☐	☐
	c. ANGINA:	☐	☐
	d. HEART FAILURE:	☐	☐
	e. SWELLING IN YOUR LEGS OR FEET (NOT CAUSED BY WALKING):	☐	☐
	f. HEART ARRHYTHMIA (HEART BEATING IRREGULARLY):	☐	☐
	g. HIGH BLOOD PRESSURE:	☐	☐
	h. ANY OTHER HEART PROBLEM THAT YOU'VE BEEN TOLD ABOUT:	☐	☐
7. HAVE YOU **EVER HAD** ANY OF THE FOLLOWING CARDIOVASCULAR OR HEART SYMPTOMS?		YES	NO
	a. FREQUENT PAIN OR TIGHTNESS IN YOUR CHEST:	☐	☐
	b. PAIN OR TIGHTNESS IN YOUR CHEST DURING PHYSICAL ACTIVITY:	☐	☐
	c. PAIN OR TIGHTNESS IN YOUR CHEST THAT INTERFERES WITH YOUR JOB:	☐	☐
	d. IN THE PAST TWO YEARS, HAVE YOU NOTICED YOUR HEART SKIPPING OR MISSING A BEAT:	☐	☐

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		YES	NO
7.	HAVE YOU **EVER HAD** ANY OF THE FOLLOWING CARDIOVASCULAR OR HEART SYMPTOMS? (CONTINUED)		
	e. HEARTBURN OR INDIGESTION THAT IS NOT RELATED TO EATING:	☐	☐
	f. ANY OTHER SYMPTOMS THAT YOU THINK MAY BE RELATED TO HEART OR CIRCULATION PROBLEMS (LIST):	☐	☐
8.	DO YOU **CURRENTLY** TAKE MEDICATION FOR ANY OF THE FOLLOWING PROBLEMS?	YES	NO
	a. BREATHING OR LUNG PROBLEMS:	☐	☐
	b. HEART TROUBLE:	☐	☐
	c. BLOOD PRESSURE:	☐	☐
	d. SEIZURES (FITS):	☐	☐
9.	IF YOU HAVE USED A RESPIRATOR, HAVE YOU **EVER HAD** ANY OF THE FOLLOWING PROBLEMS? (IF YOU HAVE NEVER USED A RESPIRATOR, CHECK THE FOLLOWING SPACE AND GO TO QUESTION 10.): ☐	YES	NO
	a. EYE IRRITATION:	☐	☐
	b. SKIN ALLERGIES OR RASHES:	☐	☐
	c. ANXIETY:	☐	☐
	d. GENERAL WEAKNESS OR FATIGUE:	☐	☐
	e. ANY OTHER PROBLEM THAT INTERFERES WITH YOUR USE OF A RESPIRATOR:	☐	☐
10.	WOULD YOU LIKE TO TALK TO THE HEALTH CARE PROFESSIONAL WHO WILL REVIEW THIS QUESTIONNAIRE ABOUT YOUR ANSWERS TO THIS QUESTIONNAIRE?	YES ☐	NO ☐

SECTION 3

		YES	NO
1.	HAVE YOU **EVER LOST** VISION IN EITHER EYE (TEMPORARILY OR PERMANENTLY)?	☐	☐
2.	DO YOU **CURRENTLY** HAVE ANY OF THE FOLLOWING VISION PROBLEMS?	YES	NO
	a. WEAR CONTACT LENSES:	☐	☐
	b. WEAR GLASSES:	☐	☐
	c. COLOR BLIND:	☐	☐
	d. ANY OTHER EYE OR VISION PROBLEM:	☐	☐
3.	HAVE YOU **EVER HAD** AN INJURY TO YOUR EARS, INCLUDING A BROKEN EAR DRUM?	YES ☐	NO ☐
4.	DO YOU **CURRENTLY** HAVE ANY OF THE FOLLOWING HEARING PROBLEMS?	YES	NO
	a. DIFFICULTY HEARING:	☐	☐
	b. WEAR A HEARING AID:	☐	☐
	c. ANY OTHER HEARING OR EAR PROBLEM:	☐	☐
5.	HAVE YOU **EVER HAD** A BACK INJURY?	YES ☐	NO ☐
6.	DO YOU **CURRENTLY** HAVE ANY OF THE FOLLOWING SYMPTOMS OF PULMONARY OR LUNG ILLNESS?	YES	NO
	a. WEAKNESS IN ANY OF YOUR ARMS, HANDS, LEGS, OR FEET:	☐	☐
	b. BACK PAIN:	☐	☐
	c. DIFFICULTY FULLY MOVING YOUR ARMS AND LEGS:	☐	☐
	d. PAIN OR STIFFNESS WHEN YOU LEAN FORWARD OR BACKWARD AT THE WAIST:	☐	☐
	e. DIFFICULTY FULLY MOVING YOUR HEAD UP OR DOWN:	☐	☐
	f. DIFFICULTY FULLY MOVING YOUR HEAD SIDE TO SIDE:	☐	☐

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		YES	NO
6.	DO YOU **CURRENTLY** HAVE ANY OF THE FOLLOWING SYMPTOMS OF PULMONARY OR LUNG ILLNESS?		
	g. DIFFICULTY BENDING AT YOUR KNEES:	☐	☐
	h. DIFFICULTY SQUATTING TO THE GROUND:	☐	☐
	i. CLIMBING A FLIGHT OF STAIRS OR A LADDER CARRYING MORE THAN 25 LBS:	☐	☐
	j. ANY OTHER MUSCLE OR SKELETAL PROBLEM THAT INTERFERES WITH USING A RESPIRATOR: (LIST)	☐	☐

SECTION 4

		YES	NO
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?	☐	☐
	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: (DESCRIBE)		
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?	☐	☐
	IF "**YES**," NAME THE CHEMICALS IF YOU KNOW THEM:		
3.	HAVE YOU EVER WORKED WITH ANY OF THE MATERIALS, OR UNDER ANY OF THE CONDITIONS, LISTED BELOW?		
	a. ASBESTOS:	☐	☐
	b. SILICA (E.G., IN SANDBLASTING):	☐	☐
	c. TUNGSTEN/COBALT (E.G., GRINDING OR WELDING THIS MATERIAL):	☐	☐
	d. BERYLLIUM:	☐	☐
	e. ALUMINUM:	☐	☐
	f. COAL (FOR EXAMPLE, MINING):	☐	☐
	g. IRON:	☐	☐
	h. TIN:	☐	☐
	i. DUSTY ENVIRONMENTS:	☐	☐
	j. ANY OTHER HAZARDOUS EXPOSURES:	☐	☐
	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?	☐	☐
	IF "**YES**," WERE YOU EXPOSED TO BIOLOGICAL OR CHEMICAL AGENTS (EITHER IN TRAINING OR COMBAT):		
8.	HAVE YOU EVER WORKED ON A HAZMAT TEAM?	☐	☐
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 MEDICATIONS):	☐	☐
	IF "**YES**," NAME THE MEDICATIONS IF YOU KNOW THEM:		

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	YES	NO
10. WILL YOU BE USING ANY OF THE FOLLOWING ITEMS WITH YOUR RESPIRATOR(S)?		
a. HEPA FILTERS:	☐	☐
b. CANISTERS (FOR EXAMPLE, GAS MASKS):	☐	☐
c. CARTRIDGES:	☐	☐
11. HOW OFTEN ARE YOU EXPECTED TO USE THE RESPIRATOR(S) (CHECK "YES" OR "NO" FOR ALL ANSWERS THAT APPLY TO YOU)?	YES	NO
a. ESCAPE ONLY (NO RESCUE):	☐	☐
b. EMERGENCY RESCUE ONLY:	☐	☐
c. LESS THAN 5 HOURS **PER WEEK:**	☐	☐
d. LESS THAN 2 HOURS **PER DAY:**	☐	☐
e. 2 TO 4 HOURS **PER DAY:**	☐	☐
f. 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: ___ **HR** ___ **MIN**		
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 - 350 KCAL PER HOUR):	YES ☐	NO ☐
IF "**YES**," HOW LONG DOES THIS PERIOD LAST DURING THE AVERAGE SHIFT: ___ **HR** ___ **MIN**		
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: ___ **HR** ___ **MIN**		
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 ARE 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 ANY SPECIAL OR HAZARDOUS CONDITIONS YOU MIGHT ENCOUNTER WHEN YOU'RE USING YOUR RESPIRATOR(S) (FOR EXAMPLE, CONFINED SPACES, LIFE-THREATENING GASES):		

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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):	
	NAME OF THE FIRST TOXIC SUBSTANCE:
	ESTIMATED MAXIMUM EXPOSURE LEVEL PER SHIFT:
	DURATION OF EXPOSURE PER SHIFT:
	NAME OF THE SECOND TOXIC SUBSTANCE:
	ESTIMATED MAXIMUM EXPOSURE LEVEL PER SHIFT:
	DURATION OF EXPOSURE PER SHIFT:
	NAME OF THE THIRD TOXIC SUBSTANCE:
	ESTIMATED MAXIMUM 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:
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):	

NEW/REHIRE EMPLOYEE/STUDENT SIGNATURE → _____ DATE/TIME_____

EHS CMA/EHS NURSE SIGNATURE → _____ DATE/TIME_____

EHS PROVIDER SIGNATURE → _____ DATE/TIME_____