`

PIVOT OCCUPATIONAL HEALTH

BASELINE MEDICAL QUESTIONNAIRE FOR RESPIRATORY CLEARANCE

Date:
Patient Name:
Patient Address:

DOB:
Patient SS#: Sex:
Phone#:

Visit Type:
Company Name:
Company Address:

Company Contact:
Company Phone #:

Part A – Section 1

1. Type of respirator you will use (check all that apply :)
   ( ) N, R, or P disposable respirator (filter-mask Non-cartridge type only)
   ( ) Other type (half or full-face piece type, powered-air purifying, supplied air, self contained breathing apparatus.)

2. Have you worn a respirator? ( ) Yes ( ) No
   If yes, what types? _____

   Place of Birth: _____

   Job Title: _____

Part A – Section 2

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? ( ) Yes ( ) No

3. Have you ever had any of the following pulmonary or lung problems?
   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 ( ) Yes ( ) No
   i. Lung Cancer ( ) Yes ( ) No
   j. Broken ribs ( ) Yes ( ) No
   k. Chest injuries or surgeries ( ) Yes ( ) No
   l. Other lung problem ( ) Yes ( ) No

5. Have you ever had any of the following cardiovascular or heart problems?
   a. Heart Attack ( ) Yes ( ) No
   b. Stroke ( ) Yes ( ) No
   c. Angina ( ) Yes ( ) No
   d. Heart failure ( ) Yes ( ) No
   e. Swelling in legs or feet (not caused by walking) ( ) Yes ( ) No
   f. Heart Arrhythmia ( ) Yes ( ) No
   g. High blood Pressure ( ) 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

8. Have you ever used a respirator? ( ) Yes ( ) No
   No – go to question 9
   Yes – have you ever had any of the following problems
   a. Eye irritation ( ) Yes ( ) No
   b. Skin allergies/rash ( ) Yes ( ) No
   c. Anxiety ( ) Yes ( ) No
   d. General weakness/fatigue ( ) Yes ( ) No
   e. Other problems that interfere with your use of a respirator? ( ) Yes ( ) No

2. Have you ever had any of the following conditions?
   a. Seizures (fits) ( ) Yes ( ) No
   b. Diabetes (sugar disease) ( ) Yes ( ) No
   c. Allergic reactions that interfere with your breathing ( ) Yes ( ) No
   d. Claustrophobia ( ) Yes ( ) No
   e. Trouble smelling odors ( ) Yes ( ) No

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of Breath ( ) Yes ( ) No
   b. Shortness of Breath when
      -walking fast ( ) Yes ( ) No
      -walking up a slight hill ( ) Yes ( ) No
      -walking with others on level ground ( ) Yes ( ) No
   c. Have to stop for breath when walking ( ) Yes ( ) No
   d. Coughing that
      -produce phlegm ( ) Yes ( ) No
      -wakes you in the morning ( ) Yes ( ) No
      -occurs when lying down ( ) Yes ( ) No
      -produces blood ( ) Yes ( ) No
   e. Wheezing that interferes with your job ( ) Yes ( ) No
   f. Chest pain when you breathe deep ( ) Yes ( ) No
   g. Symptoms that might be related to lung problems ( ) Yes ( ) No

6. Have you ever had any of the following cardiovascular or heart symptoms?
   a. Frequent pain or tightness in your chest ( ) Yes ( ) No
   b. Pain or tightness in chest during physical activity ( ) Yes ( ) No
   c. Pain or tightness in 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/indigestion not related to eating ( ) Yes ( ) No
   f. Any other symptoms that you think may be related to heart or circulation problems ( ) Yes ( ) No

9. Would you like to talk to the health care professional who will review this questionnaire? ( ) Yes ( ) No

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Questions 10 through 15 must be answered by every employee who wears either a full-face respirator or a self contained breathing apparatus (SCBA)

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

11. Do you currently have any of the following visual problems?
    a. Wear contact Lenses ( ) Yes ( ) No
    b. Wear glasses ( ) Yes ( ) No
    c. Color blind ( ) Yes ( ) No
    d. Any other eye or vision problems ( ) Yes ( ) No

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?
    a. Difficulty hearing ( ) Yes ( ) No
    b. Wear a hearing aid ( ) Yes ( ) No
    c. Any other hearing or ear problems ( ) Yes ( ) No

14. Have you ever had a back injury? ( ) Yes ( ) No

15. Do you currently have any of the following musculoskeletal problems?
    a. Weakness in any of your arms, hands, legs or feet ( ) Yes ( ) No
    b. Back Pain ( ) Yes ( ) No
    c. Difficulty moving your arms and legs ( ) Yes ( ) No
    d. Pain or stiffness when you lean forward or backward at the waist ( ) Yes ( ) No
    e. Difficulty 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
    i. Difficulty climbing a flight of stairs or a ladder while carrying more than 25 lbs ( ) Yes ( ) No
    j. Any other muscle or skeletal problem that interferes with using a respirator ( ) Yes ( ) No

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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, names 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	( ) Yes ( ) No	f. Coal	( ) Yes ( ) No
b. Silica (e.g. sandblasting)	( ) Yes ( ) No	g. Iron	( ) Yes ( ) No
c. Tungsten/cobalt		h. Tin	( ) Yes ( ) No
(grinding or welding this material)	( ) Yes ( ) No	i. Dusty Environments	( ) Yes ( ) No
d. Beryllium	( ) Yes ( ) No	j. Any other hazardous	
e. Aluminum	( ) Yes ( ) No	exposures	( ) Yes ( ) No

   If yes – describe exposures: _____
   _____

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

5. List your previous occupations: _____

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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 medications for any reason (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?

    a. HEPA Filters ( ) Yes ( ) No
    b. Canisters (e.g. gas masks) ( ) Yes ( ) No
    c. Cartridges ( ) Yes ( ) No

11. How often are you expected to use the respirators (s)? Check a response for all that apply.

    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 20kcal per hour) ( ) Yes ( ) No
    If "yes", how long does this period last during the average shift: _____hrs._____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 to 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 _____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 2mph 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 _____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 at 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 degrees Fahrenheit? ( ) Yes ( ) No

15. Will you be working under humid conditions? ( ) Yes ( ) No

BASELINE MEDICAL QUESTIONNAIRE FOR RESPIRATORY CLEARANCE-Page 4

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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)

_____

_____

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 Toxic Substance	Estimated Maximum Exposure Level Per Shift	Duration of Exposure Per Shift

List the name of any other toxic substance that you'll be exposed to while using 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) _____

_____

_____

_____
Patient Signature

_____
Reviewing providers Signature