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| d. Claustrophobia (fear of closed-in places)? | Yes | No |
| e. Trouble smelling odors? | Yes | No3. |
| 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 (collapsed lung) | Yes | No |
| i. Lung Cancer | Yes | No |
| j. Broken Ribs | Yes | No |
| k. Any chest injuries or surgeries | Yes | No |
| l. Any other lung problem that you've been told about | 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 on level ground or walking up a slight hill or incline | Yes | No |
| c. Shortness of breath when walking with other people at an ordinary pace on level ground | Yes | No |
| d. Have to stop for breath when walking at your own pace on level ground | Yes | No |
| e. Shortness of breath when washing/dressing yourself | Yes | No |
| f. Shortness of breath that interferes with your job | Yes | No |
| g. Coughing that produces phlegm (thick sputum) | Yes | No |
| h. Coughing that wakes you early in the morning | Yes | No |
| i. Coughing that occurs mostly when you are lying down | Yes | No |
| j. Coughing up blood in the last month | Yes | No |
| k. Wheezing | Yes | No |
| l. Wheezing that interferes with your job | Yes | No |
| m. Chest pain when you breathe deeply | Yes | No |
| n. Any other symptoms that you think may be related to lung problems | 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 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 problem that you've been told about | 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 your chest during physical activity | Yes | No |

- c. Pain or tightness in your 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 or indigestion that is not related to eating Yes No
- f. Any other symptom you think may be related to heart or circulation problems 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. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check here _____ and go on to question 9.)

- 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 problem that interferes with your use of a respirator Yes No

9. Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire **(If yes, call Occupational Health Unit at 71977.)** Yes No

10. If you have questions about the respirator use, workplace hazards or fit-testing, contact Safety Service Industrial Hygienist at 7-2080.

Employee Printed Name _____ Signature _____

Date _____

FOR OCCUPATIONAL HEALTH PROVIDER USE ONLY

1. Medically cleared to use the N95 respirator (filter mask).

2. Medically cleared with restrictions as shown: _____

3. Further evaluation needed.

4. Medically not cleared.

(Printed Name/Signature)
Occupational Health Provide

Date