



5151 Katy Fwy #170 Houston, TX 77007 Tel (713) 802-1020

Respirator Medical Qualification/ Silica Questionnaire

Company _____

Employee's Name: _____ DOB: _____ Age: _____

Current Job Title: _____ Department: _____

Job Phone #: _____ Home Phone #: _____ ID #: _____

Gender: Male Female

Home Address: _____ (street)

_____ (City, State, Zip)

Best Time, Place, and number to call you if needed? _____

Date of Form _____ Date of Last Respirator Physical _____

HIPAA Statement/Notice of Privacy

PURPOSE

The purpose of this form is to obtain information about your personal health and work exposures. This information will be gathered by a Baker Concrete Construction, Inc. (Baker) co-worker and sent to an Occupational Health Professional (OHP) to make an accurate assessment of your ability to safely wear a respirator. The OHP will evaluate the information on this form and provide a report to Baker. Baker has contracted with OccuCare to provide these services.

PRIVACY STATEMENT

The following information requested on the form is private: date of birth, sex, home address and all items under *Medical History*. The OHC at OccuCare will not release any private information about you without your written consent, except as required by law. The OHC at OccuCare will notify Baker of the following: whether you are medically cleared to wear a respirator, type of respirator you are medically cleared to wear, and if any medical follow up is necessary.

Job-Related Information

Number of hours worked in silica-related tasks per week:

- 10-20
- 20-30
- 30-40
- More than 40 (_____ hours)

List previous jobs and duration of each job:

- a. _____ (___ yrs.)
- b. _____ (___ yrs.)
- c. _____ (___ yrs.)
- d. _____ (___ yrs.)

Time at current job:

- Six months or less
- 1-2 yrs

3-5 yrs

More than 5 yrs. (_____ yrs.)

Have you been told that you have worked in a job that exposed you to silica in the past?

Yes No

Have you used a respirator or respiratory protection while on the job in the past?

Yes No

C. Brief Medical History

Are you being treated by a physician for breathing problems? Yes No

Have you ever had a chest X-ray? Yes No

If yes, when was your last chest X-ray? _____

Why was the chest X-ray taken? _____

Did the doctor tell you everything was normal? Yes No

If no, what was noted? _____

Did you receive treatment for this problem, if any? _____

Do you currently smoke cigarettes? Yes No

How many packs per day? _____ For how many years? _____

Did you smoke cigarettes previously? Yes No
If yes, how long ago did you quit? _____

Do you have any of the following medical issues now, or within the last year?

- | | | | | | |
|-------------------|------------------------------|-----------------------------|------------------------|------------------------------|-----------------------------|
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Coughing up blood | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lung Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Chronic Sinus Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chronic Cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Recurrent Sore Throat | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chronic Allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please explain any 'Yes' answers:

Do you now or within the last year use any medication to treat a respiratory disorder?
(antibiotics, inhalers, breathing treatments, etc.) Yes No

If yes, please list names, frequency of use, and why they are used:

Would you like to speak to a healthcare professional regarding your medical history as it relates to silica exposure?
 Yes No

Signature

Date

Note: Answers to questions in Sec 1, and to question 9 in Section 2 of Part A, do not require a medical examination

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. Social Security #	-	-
3. Home Street address		4. City, State, Zip		
5. Your Age		6. D.O.B.	/	/
		7. Sex (circle one)	Male	-
				Female
8. Your Height	feet	Inches	9. Weight	lbs.
10. Job title		11. Department		
12. Job Phone #		13. Home Phone #		
14. Best Time and Place to Call you if need be?				
15. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes / No				
16. Check the type of respirator you will use (you can check more than one category):				
A. _____ (N) Non Oil, (R) Oil Resistant, or (P) Oil Proof disposable respirator (filter-mask, non- cartridge type only).				
B. _____ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).				
17. Have you worn a respirator (circle one): Yes - No			What types?	

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you <i>currently</i> smoke tobacco, or have you smoked tobacco in the last month?	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 reaction that interfere with your breathing	YES	NO
d. Claustrophobia (fear of closed-in places)	YES	NO
e. Trouble smelling odors	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 (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 <i>currently</i> 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 or 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 symptoms that 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 the following space and go 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 health care professional who will review this questionnaire about your answers to this Questionnaire	YES NO

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you <i>ever lost</i> vision in either eye (temporarily or permanently)	YES NO
11. Do you <i>currently</i> have any of the following vision problems?	
a. Wear contact lenses	YES NO
b. Wear glasses	YES NO
c. Color blind	YES NO
d. Any other eye or vision problem	YES NO
12. Have you <i>ever had</i> an injury to your ears, including a broken ear drum	YES NO
13. Do you <i>currently</i> 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 problem	YES NO
14. Have you <i>ever had</i> a back injury	YES NO
15. Do you <i>currently</i> 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 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:	YES NO

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're 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	
3. Have you ever worked with any of the materials, or under any of the conditions, listed below	
a. Asbestos	YES NO
b. Silica (e.g., in sandblasting):	YES NO
c. Tungsten/cobalt (e.g., grinding or welding this material):	YES NO
d. Beryllium	YES NO
e. Aluminum	YES NO
f. Coal (for example, mining):	YES NO
g. Iron	YES NO
h. Tin	YES NO
i. Dusty environments	YES NO
j. Any other hazardous exposures	YES NO
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	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(s)?	
a. HEPA Filters	YES NO
b. Canisters (for example, gas masks):	YES NO
c. Cartridges	YES NO

**11. How often are you expected to use the respirator(s)
(Circle "yes" or "no" for all answers that apply to you)?**

a. Escape only (no rescue):	YES NO
b. Emergency rescue only	YES NO
c. Less than 5 hours <i>per week</i>	YES NO
d. Less than 2 hours <i>per day</i>	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. <i>Light</i> (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 <i>sitting</i> while writing, typing, drafting, or performing light assembly work; or <i>standing</i> while operating a drill press (1-3 lbs.) or controlling machines.	
b. <i>Moderate</i> (200 to 350 kcal per hour):	YES NO
If "yes," how long does this period last during the average shift: _____ hrs. _____ mins. Examples of moderate work effort are <i>sitting</i> while nailing or filing; <i>driving</i> a truck or bus in urban traffic; <i>standing</i> while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; <i>walking</i> on a level surface about 2 mph or down a 5-degree grade about 3 mph; or <i>pushing</i> a wheelbarrow with a heavy load (about 100 lbs.) on a level surface	
c. <i>Heavy</i> (above 350 kcal per hour):	YES NO
If "yes," how long does this period last during the average shift: _____ hrs. _____ mins. Examples of heavy work are <i>lifting</i> a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; <i>shoveling</i> ; <i>standing</i> while bricklaying or chipping castings; <i>walking</i> 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're using your respirator	YES NO
If "yes," describe this protective clothing and/or equipment	
14. Will you be working under hot conditions - temp.greater than 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)	
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):	
a. Name of the first toxic substance	
Estimated maximum exposure level per shift	
Duration of exposure per shift	
b. Name of the second toxic substance	
Estimated maximum exposure level per shift	
Duration of exposure per shift	
c. Name of the third toxic substance	
Estimated maximum exposure level per shift	
Duration of exposure per shift	
d. 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):	

Please Complete the Respirator Medical Qualification Signature and Comment Page