Michigan State University
University Physician's Office
Occupational Health (517) 353-9137
East Lansing, MI 48824-1037

INITIAL MEDICAL QUESTIONNAIRE FOR INDIVIDUALS WHO WEAR A RESPIRATOR

INSTRUCTIONS: Please answer all questions honestly and completely. Questions are for record keeping purposes and to check for heart or lung disease that may place you at risk of becoming ill when you wear a respirator. Information will be kept confidential and will be reviewed by professional medical personnel only. If you wish to talk to the Health Care Professional who will be reviewing this questionnaire, please call MSU Occupational Health at 353-9137.

Name: _____ Last _____ First _____ Middle	
Address: _____ Street _____ City _____ State _____ Zip	
Home Phone: ( )	Gender: ☐ Male ☐ Female
ZPID or APID:	Date of Birth:
Department:	Job Title:
Phone number we can reach you at work:	Supervisor:
Were you ever an MSU Student? Yes___ No ___ If Yes, Student #:_____	
Height: (without shoes)	
Weight: (without shoes)	

Yes No

1. ☐ ☐ Have you ever smoked cigarettes? (“Yes” means more than 20 packs of cigarettes or 12 oz. of tobacco in your life)

IF “YES,” ANSWER QUESTIONS 1a-4e. IF “NO,” SKIP TO QUESTION 2.

Yes No

☐ ☐ 1a. Do you smoke now?

1b. How old were you when you started smoking regularly? _____

1c. If you stopped, how old were you when you stopped? _____

1d. On the average, how many packs per day have you smoked for the length of time you smoked? _____

1e. How many packs per day do you smoke now? _____

Yes No

2. ☐ ☐ Have you ever had a back injury?

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

Yes No

☐ ☐ 3a. Weakness in any of your arms, hands, legs, or feet

Yes No

☐ ☐ 3b. Back pain

Yes No

☐ ☐ 3c. Difficulty fully moving your head up or down

Yes No

☐ ☐ 3d. Pain or stiffness when you lean forward or backward at the waist

Yes No

☐ ☐ 3e. Difficulty fully moving your head side to side

Yes No

☐ ☐ 3f. Difficulty fully bending at your knees

Yes No

☐ ☐ 3g. Difficulty squatting to the ground

Yes No

☐ ☐ 3h. Difficulty climbing a flight of stairs or a ladder while carrying more than 25 lbs.

Yes No

☐ ☐ 3i. Any other muscle or skeletal problem that might interfere with using a respirator
IF “YES”, PLEASE EXPLAIN:

4. Check the type of respirator (a mask that protects you against exposure to dusts or chemical fumes) you will use, (you can check more than one category):

☐ 4a. N, R, or P disposable respirator (filter-mask, non cartridge type only).

☐ 4b. Other type (for example, half or full-face piece type, powered-air purifying, supplied-air self contained breathing apparatus).

☐ 4c. How often do you expect to wear a respirator? (for example: 3 times per week, 10 times per month)

☐ 4d. How long do you expect to typically wear your respirator without taking it off? (for example: 15 min., .5 hours, 1 hour, 4 hours)

☐ 4e. What duties will you perform while using the respirator? (for example: painting, applying pesticides, cleaning, asbestos removal, etc…)

☐ 4f. Briefly describe your working environment when you will be wearing your respirator. (For example: research lab, farm area, steam tunnel, penthouse, etc…)

Yes No

5. ☐ ☐ Have you ever worn a respirator:
IF "YES," ANSWER QUESTIONS 5a-5i. IF "NO," SKIP TO QUESTION 6.

5a. When was the last time, year?

5b. Check the type: ☐ Paper (surgical) mask ☐ cartridge ☐ helmet ☐ air tank

Yes No Have you ever had any of the following problems when you wore a respirator?

☐ ☐ 5c. Eye irritation?

Yes No

☐ ☐ 5d. Skin allergies or rashes?

Yes No

☐ ☐ 5e. Anxiety?

Yes No

☐ ☐ 5f. Persistent general weakness or fatigue?

Yes No

☐ ☐ 5g. Any other problems that interfere with your use of a respirator?
If yes, what? _____

Yes No

☐ ☐ 5h. Describe any other difficulties that you had using the respirator?

Yes No

☐ ☐ 5i. Did these difficulties make it so you were unable to use the respirator?

Yes No

6. ☐ ☐ Are you color blind?

Yes No

7. ☐ ☐ Do you wear contact lenses?

Yes No

8. ☐ ☐ Do you wear glasses?

Yes No

9. ☐ ☐ Do you have a fear of tight or enclosed places (claustrophobia)?

Yes No

10. ☐ ☐ Do you have a sensation of smothering?

Yes No

11. ☐ ☐ Do you have a ruptured ear drum?

Yes No

12. ☐ ☐ Have you ever had a breathing test
IF "YES", WHAT WERE THE RESULTS?

Normal _____ Abnormal _____ Don't Know _____

Yes No

13. ☐ ☐ Have you ever had an electrocardiogram?
IF "YES", WHAT WERE THE RESULTS?

Normal _____ Abnormal _____ Don't Know _____

Yes No

14. ☐ ☐ Do you have a beard?
IF "YES", WOULD YOU SHAVE YOUR BEARD IF YOU WERE REQUIRED TO FOR A JOB?

Yes No

15. ☐ ☐ Do you consider yourself to be in good health?
IF "NO", STATE REASONS:

16. Yes ☐ No ☐ Do you have any defect of vision (other than corrective lenses)?
IF "YES", STATE THE NATURE OF THE DEFECT:

17. Yes ☐ No ☐ Do you have any defect of hearing?
IF "YES", STATE THE NATURE OF THE DEFECT:

18. Have you ever had any of the following conditions?

Yes ☐ No ☐ 18a. Epilepsy (or fits, seizures, convulsions)?

Yes ☐ No ☐ 18b. Rheumatic Fever?

Yes ☐ No ☐ 18c. Kidney Disease?

Yes ☐ No ☐ 18d. Bladder Disease?

Yes ☐ No ☐ 18e. Diabetes?
IF "YES," Check treatment(s): ☐ **DIET** ☐ **PILLS** ☐ **INSULIN**

Yes ☐ No ☐ 18f. Allergic reactions that interfere with your breathing?

Yes ☐ No ☐ 18g. Jaundice?

Yes ☐ No ☐ 18h. Trouble smelling odors?

19. Yes ☐ No ☐ Have you ever had emphysema?
IF "YES", ANSWER QUESTIONS 19A-19C. IF "NO", SKIP TO QUESTION 20.

Yes ☐ No ☐ 19a. Do you still have it?

Yes ☐ No ☐ 19b. Did a doctor confirm it?

19c. At what age did it start? _____

20. Yes ☐ No ☐ Have you ever had asthma?
IF "YES", ANSWER QUESTIONS 20A-20D. IF "NO", SKIP TO QUESTION 21.

Yes ☐ No ☐ 20a. Do you still have it?

Yes ☐ No ☐ 20b. Did a doctor confirm it?

20c. At what age did it start? _____

20d. If you no longer have it, at what age did it stop? _____

21. Have you ever had any of the following lung conditions?

Yes	No		
☐	☐	21a.	Chronic bronchitis
☐	☐	21b.	Pneumonia
☐	☐	21c.	Tuberculosis
☐	☐	21d.	Silicosis
☐	☐	21e.	Pneumothorax (ruptured or collapsed lung)
☐	☐	21f.	Lung cancer
☐	☐	21g.	Broken ribs

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

Yes	No		
☐	☐	22a.	Shortness of breath that interferes with your job
☐	☐	22b.	Coughing that produces phlegm (thick sputum)
☐	☐	22c.	Coughing that wakes you early in the morning
☐	☐	22d.	Coughing that occurs mostly when you are lying down
☐	☐	22e.	Coughing up blood in the last month
☐	☐	22f.	Wheezing that interferes with your job
☐	☐	22g.	Chest pain when you breathe deeply
☐	☐	22h.	Any other symptoms that you think may be related to lung problems

Yes	No	
☐	☐	23. Have you ever had any other chest illness? **IF "YES", PLEASE SPECIFY:**

Yes	No	
☐	☐	24. Have you ever had any surgery on your chest? **IF "YES", PLEASE SPECIFY:**

Yes	No	
☐	☐	25. Have you ever had any chest injuries? **IF "YES", PLEASE SPECIFY:**

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

Yes	No	
☐	☐	26a. Stroke?
☐	☐	26b. Angina? (Heart pain)
☐	☐	26c. Heart failure?
☐	☐	26d. Swelling in your legs or feet (not caused by walking)?
☐	☐	26e. Heart arrhythmia (heart beating irregularly)?

Yes No

27. ☐ ☐ Has a doctor ever told you that you had a heart attack?

Yes No

28. ☐ ☐ Has a doctor ever told you that you had any other kind of heart trouble?
IF "YES," PLEASE SPECIFY:

Yes No

29. ☐ ☐ Do you have irregular or skipped heartbeats?

30. What was your most recent blood pressure? ____/____

You must provide a blood pressure reading done within the past year. If you have not had a blood pressure reading in the last year, have a blood pressure taken and record the result on the questionnaire before sending the questionnaire to the Occupational Health Clinic. You may also call the Occupational Health Clinic (353-9137) to schedule a time to have your blood pressure taken and you may return the questionnaire at that time.

Yes No

31. ☐ ☐ Has a doctor ever told you that you had high blood pressure?

Yes No

32. ☐ ☐ Have you had any treatment for high blood pressure (hypertension) in the past ten years?
IF "YES," PLEASE LIST WHAT MEDICATION(s) YOU TAKE FOR YOUR HIGH BLOOD PRESSURE:

Yes No

33. ☐ ☐ Do you ever have wheezy or whistling sounds in your chest?

IF "YES", ANSWER QUESTIONS 33A-33C. IF "NO", SKIP TO 34.

Yes No

☐ ☐ 33a. When you have a cold

Yes No

☐ ☐ 33b. Occasionally, apart from a cold

Yes No

☐ ☐ 33c. Most days or nights

IF YOU ANSWERED "YES" TO QUESTIONS A, B, OR C, THEN ANSWER QUESTION 33D.

Yes No

☐ ☐ 33d. How many years has this been present? _____

Yes No

34. ☐ ☐ Have you ever had an attack of wheezing that made you feel short of breath?

IF "YES", ANSWER QUESTIONS 34A-34C. IF "NO", SKIP TO 35.

34a. How old were you when your first attack of wheezing occurred?
Age in years _____ Does not apply _____

Yes No

☐ ☐ 34b. Have you had two or more such episodes?

Yes No

☐ ☐ 34c. Have you required medicine or treatment for these attacks?

Yes No

35. ☐ ☐ Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?

Yes No

36. ☐ ☐ Do you have to walk slower than other people your age do on the level because of breathlessness?

Yes No

37. ☐ ☐ Do you ever have to stop for breath when walking at your own pace on the level?

Yes No

38. ☐ ☐ Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level?

Yes No

39. ☐ ☐ Are you too breathless to leave the house or too breathless when you get dressed or climb the stairs?

40. When was your last general medical examination? _____

41. List all medications you take on a regular basis (include those you can buy without a prescription). If you don't know the name, list what the pill is for (i.e., "heart pill" or "water pill"). Use back if more room is needed.

_____ for _____ _____ for _____
_____ for _____ _____ for _____
_____ for _____ _____ for _____

42. Have you ever had any of the following cardiovascular or heart symptoms?

Yes ☐ No ☐ 42a. Pain or tightness in your chest that interferes with your job

Yes ☐ No ☐ 42b. Heartburn or indigestion that is not related to eating

Yes ☐ No ☐ 42c. Any other symptoms that you think may be related to heart or circulation problems.
IF "YES," PLEASE SPECIFY:

Within the past three months:

43. Yes ☐ No ☐ Have you had any pain or discomfort in your chest?

44. Yes ☐ No ☐ Have you ever had any pressure or heaviness in your chest?
IF "YES" TO EITHER QUESTIONS 43 OR 44, ANSWER THE FOLLOWING QUESTIONS.
IF "NO" TO QUESTIONS 43 AND 44, SKIP TO QUESTION 51.

45. Yes ☐ No ☐ Do you get pain, discomfort, pressure, or heaviness when you walk uphill or hurry?
☐ I never hurry or walk uphill

46. Yes ☐ No ☐ Do you get pain, discomfort, pressure, or heaviness when you walk at an ordinary pace on level ground?

47. What do you do if you get pain, discomfort, pressure, or heaviness while you are walking?
☐ Stop or slow down
☐ Take nitroglycerine
☐ Keep going, without slowing down

48. If you stand still or sit down, what happens to this pain or discomfort?
☐ Not relieved ☐ Relieved

49. Yes ☐ No ☐ Did you see a doctor because of this pain or discomfort?
IF "YES," WHAT DID HE/SHE SAY IT WAS?

50. If disabled from walking by any condition other than heart or lung disease, describe the nature of the condition(s):

51. Yes ☐ No ☐ Would you like to talk to the health care professional that will review this questionnaire about your answers to this questionnaire?

You are done! Please mail or fax this completed questionnaire to: MSU Occupational Health, 463 East Circle Drive, Room 123 Olin Health Center, East Lansing, MI 48824. Fax: (517) 355-0332.