

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: ()	
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)	

1. Yes No 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.

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? _____

2. Yes No 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...)

5. Yes No 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? _____
- 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?
6. Yes No Are you color blind?
7. Yes No Do you wear contact lenses?
8. Yes No Do you wear glasses?
9. Yes No Do you have a fear of tight or enclosed places (claustrophobia)?
10. Yes No Do you have a sensation of smothering?
11. Yes No Do you have a ruptured ear drum?
12. Yes No Have you ever had a breathing test
IF "YES", WHAT WERE THE RESULTS?
- Normal _____ Abnormal _____ Don't Know _____
13. Yes No Have you ever had an electrocardiogram?
IF "YES", WHAT WERE THE RESULTS?
- Normal _____ Abnormal _____ Don't Know _____
14. Yes No Do you have a beard?
IF "YES", WOULD YOU SHAVE YOUR BEARD IF YOU WERE REQUIRED TO FOR A JOB?
15. Yes No 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 | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 21a. | Chronic bronchitis |
| Yes | No | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 21b. | Pneumonia |
| Yes | No | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 21c. | Tuberculosis |
| Yes | No | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 21d. | Silicosis |
| Yes | No | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 21e. | Pneumothorax (ruptured or collapsed lung) |
| Yes | No | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 21f. | Lung cancer |
| Yes | No | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 21g. | Broken ribs |

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

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

23. Yes No Have you ever had any other chest illness?

IF "YES", PLEASE SPECIFY:

24. Yes No Have you ever had any surgery on your chest?

IF "YES", PLEASE SPECIFY:

25. Yes No 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 | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 26a. | Stroke? |
| Yes | No | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 26b. | Angina? (Heart pain) |
| Yes | No | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 26c. | Heart failure? |
| Yes | No | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 26d. | Swelling in your legs or feet (not caused by walking)? |
| Yes | No | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 26e. | Heart arrhythmia (heart beating irregularly)? |

27. Yes No Has a doctor ever told you that you had a heart attack?
28. Yes No Has a doctor ever told you that you had any other kind of heart trouble?
IF "YES," PLEASE SPECIFY:

29. Yes No 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.

31. Yes No Has a doctor ever told you that you had high blood pressure?
32. Yes No 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:

33. Yes No 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? _____

34. Yes No 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?

35. Yes No Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?

36. Yes No Do you have to walk slower than other people your age do on the level because of breathlessness?

37. Yes No Do you ever have to stop for breath when walking at your own pace on the level?

38. Yes No Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level?

39. Yes No 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.