

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

**INTERIM 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.

- 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. Yes No Have you worn a respirator since completing your last respirator questionnaire?

IF "YES," ANSWER QUESTIONS 4a-4m.

IF "NO," SKIP TO QUESTION 5.

4a. How often do wear a respirator? (for example: 3 times per week, 10 times per month)
_____ per week _____ per month _____ per year

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

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

4d. Briefly describe your working environment while wearing your respirator. (For example: research lab, farm area, steam tunnel, penthouse, etc...)

4e. What type of respirator do you wear? (check **all** that apply)

- Disposable paper dust mask with 1 strap
- Disposable paper dust mask with 2 straps (Fig. A)
- Disposable organic vapor mask (Fig. B)
- Disposable organic vapor/acid gas mask (Fig. B)
- Reusable half-face mask (Fig. C.)
- Reusable full-face mask (Fig. D)
- Powered air purifying respirator (Fig. E)
- Full-face respirator with an air-line
- Self contained breathing apparatus (SCBA)
- Air-line w/ total body suit
- Other (please specify)



Fig. A



Fig. B



Fig. C



Fig. D



Fig. E

4f. Indicate, with a check, whether your usual workload level while you are wearing a respirator is resting, light, moderate, or heavy. Also, indicate with a check, whether your maximum workload level while you are wearing a respirator is resting, light, moderate, or heavy.

Usual Max.

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Resting |
| <input type="checkbox"/> | <input type="checkbox"/> | Light (examples include)—sitting at ease, light hand work, hand and arm work (small bench tools, inspecting, assembly, or sorting of light materials), arm and leg work. Standing: drill press (small parts), milling machine (small parts), machining with light power tools. |
| <input type="checkbox"/> | <input type="checkbox"/> | Moderate (examples include)—hand and arm work (nailing, filing), arm and leg work (off road operation of trucks or construction equipment), arm and trunk work (air hammer operation, tractor assembly, plastering, intermittent handling of moderately heavy materials, weeding, hoeing, pushing or pulling light weight cars or wheelbarrows). |
| <input type="checkbox"/> | <input type="checkbox"/> | Heavy (examples include)—heavy arm and trunk work, transferring heavy materials, shoveling, sledge hammer work, sawing, hand mowing, digging, axe work, climbing stairs or ramps, jogging, running, pushing or pulling heavily loaded carts or wheelbarrows, chipping castings, concrete block laying. |

Have you ever had any of the following problems when you wore a respirator?

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | 4g. Eye irritation? |
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | 4h. Skin allergies or rashes? |
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | 4i. Anxiety? |
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | 4j. Persistent general weakness or fatigue? |
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | 4k. Any other problems that interfere with your use of a respirator?
If yes, what? |
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | 4l. Describe any other difficulties that you had using the respirator? |
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | 4m. Were you unable to use the respirator because of these difficulties? |
| 5. | <input type="checkbox"/> | Do you have a fear of tight or enclosed places (claustrophobia)? |
| 6. | <input type="checkbox"/> | Do you have a sensation of smothering? |
| 7. | <input type="checkbox"/> | Do you have a ruptured ear drum? |
| 8. | <input type="checkbox"/> | Do you wear contact lenses? |

9. Yes No Do you wear glasses?
10. Yes No Have you ever had to have medical treatment for heat exhaustion or heat stroke?
11. Yes No Have you had a breathing test since completing your first respirator questionnaire?

IF "YES", WHAT WERE THE RESULTS?

Normal _____ Abnormal _____ Don't Know _____

12. Yes No Have you had an electrocardiogram since completing your last respirator questionnaire?
- IF "YES", WHAT WERE THE RESULTS?**

Normal _____ Abnormal _____ Don't Know _____

13. Yes No Do you consider yourself to be in good health?
- IF "NO", STATE REASONS:**

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

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

-
16. Have you ever had any of the following conditions?

Yes No 16a. Epilepsy (or fits, seizures, convulsions)?

Yes No 16b. Rheumatic Fever?

Yes No 16c. Kidney Disease?

Yes No 16d. Bladder Disease?

Yes No 16e. Diabetes?

IF "YES," Check treatment(s): DIET PILLS INSULIN

Yes No 16f. Allergic reactions that interfere with your breathing?

Yes No 16g. Jaundice?

Yes No 16h. Trouble smelling odors?

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

Yes No 17a. Chronic bronchitis

Yes No 17b. Pneumonia

Yes No 17c. Tuberculosis

- Yes No
 17d. Silicosis
 Yes No
 17e. Pneumothorax (ruptured or collapsed lung)
 Yes No
 17f. Lung cancer
 Yes No
 17g. Emphysema
 Yes No
 17h. Asthma
18. Do you currently have any of the following symptoms of pulmonary or lung illness?
- Yes No
 18a. Shortness of breath that interferes with your job
 Yes No
 18b. Coughing that produces phlegm (thick sputum)
 Yes No
 18c. Coughing that wakes you early in the morning
 Yes No
 18d. Coughing that occurs mostly when you are lying down
 Yes No
 18e. Coughing up blood in the last month
 Yes No
 18f. Wheezing that interferes with your job
 Yes No
 18g. Chest pain when you breathe deeply
 Yes No
 18h. Any other symptoms that you think may be related to lung problems
19. Since completing your last respirator questionnaire have you had any other chest illness?
IF "YES", PLEASE SPECIFY:
-
20. Yes No
 Since completing your last respirator questionnaire have you had any surgery on your chest?
IF "YES", PLEASE SPECIFY:
-
21. Yes No
 Since completing your last respirator questionnaire have you had any chest injuries?
IF "YES", PLEASE SPECIFY:
-
22. Since completing your last respirator have you had any of the following cardiovascular or heart problems?
- Yes No
 22a. Stroke?
 Yes No
 22b. Angina? (heart pain)
 Yes No
 22c. Heart failure?
 Yes No
 22d. Swelling in your legs or feet (not caused by walking)?
 Yes No
 22e. Heart arrhythmia (heart beating irregularly)?
23. Since completing your last respirator questionnaire has a doctor told you that you had a heart attack?

24. Yes No Since completing your last respirator questionnaire has a doctor told you that you had any other kind of heart trouble?
IF "YES," PLEASE SPECIFY:

25. Yes No Do you have irregular or skipped heartbeats?

26. 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.

27. Yes No Has a doctor ever told you that you had high blood pressure?

28. 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:

29. Yes No Do you ever have wheezy or whistling sounds in your chest?

IF "YES", ANSWER QUESTIONS 29A-29C. IF "NO", SKIP TO 30.

Yes No 29a. When you have a cold

Yes No 29b. Occasionally, apart from a cold

Yes No 29c. Most days or nights

IF YOU ANSWERED "YES" TO QUESTIONS A, B, OR C, THEN ANSWER QUESTION 29D.

Yes No 29d. How many years has this been present? _____

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

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

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

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

34. Yes No Are you too breathless to leave the house or too breathless when you get dressed or climb the stairs?

35. When was your last general medical examination? _____

36. 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 _____

37. Have you ever had any of the following cardiovascular or heart symptoms?
- 37a. Pain or tightness in your chest that interferes with your job
 37b. Heartburn or indigestion that is not related to eating
 37c. Any other symptoms that you think may be related to heart or circulation problems.
- IF "YES," PLEASE SPECIFY:**

Within the past three months:

38. Yes No
 Have you had any pain or discomfort in your chest?
39. Yes No
 Have you ever had any pressure or heaviness in your chest?
**IF "YES" TO EITHER QUESTIONS 38 OR 39, ANSWER THE FOLLOWING QUESTIONS.
IF "NO" TO QUESTIONS 38 AND 39, SKIP TO QUESTION 46.**
40. Yes No
 Do you get pain, discomfort, pressure, or heaviness when you walk uphill or hurry?
 I never hurry or walk uphill
41. Yes No
 Do you get pain, discomfort, pressure, or heaviness when you walk at an ordinary pace on level ground?
42. 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
43. If you stand still or sit down, what happens to this pain or discomfort?
 Not relieved Relieved
44. Yes No
 Did you see a doctor because of this pain or discomfort?
IF "YES," WHAT DID HE/SHE SAY IT WAS?
45. If disabled from walking by any condition other than heart or lung disease, describe the nature of the condition(s):
46. 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.