





What type of respirator(s) will you use?

(You may check more than one category. For "Other types", please indicate specific type(s).)

- 048-  N, R, or P disposable respirator\* (filter-mask, non-cartridge type only)
- 049-  Other types: 050-  half-facepiece 051-  full-facepiece 052-  powered air-purifying  
053-  supplied-air 054-  self-contained breathing apparatus (SCBA)

YES NO

- 055  Will any of the following be used with respirator(s)? (Please indicate specific type if known.)  
056-  HEPA filters, 057-  Canisters (e.g., gas masks), 058-  Cartridges
- 059  Are there any current/potential conditions for which your employer has indicated you are/  
will be required to use a respirator?  
060- If yes, please describe: \_\_\_\_\_

How often will you be required to use or voluntarily use respirator(s)?

- 061-  More than 4 hours per day, 062-  2 to 4 hours per day, 063-  1 to 2 hours per day,  
064-  Less than 5 hours per week, 065-  Emergency rescue only, 066-  Escape use only (no rescue)  
067-  Other \_\_\_\_\_

Please indicate expected work effort during respirator use and time period of effort within an average shift. (Please use more than one category if applicable.)

- 068-  Light (less than 200 kcal per hour) 069-  Hours  Minutes

Examples of LIGHT WORK EFFORT are sitting while writing, typing, drafting or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.

- 070-  Moderate (200 to 350 kcal per hour) 071-  Hours  Minutes

Examples of MODERATE WORK EFFORT are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

- 072-  Heavy (more than 350 kcal per hour) 073-  Hours  Minutes

Examples of HEAVY WORK EFFORT are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

YES NO

- 074  Will you be wearing protective clothing and/or other equipment when using a respirator?  
075- If yes, please describe: \_\_\_\_\_

- 076  Will you be working in temperatures exceeding 77½F?

077- If yes, please indicate maximum temperature  ½F

- 078  Will you be working under humid conditions? 079- If yes, please describe: \_\_\_\_\_

- 080  Will you be working at high altitudes (over 5,000 ft.) or in a place that has lower than normal amounts of oxygen? If yes, have you had:

081-  Feelings of dizziness 082-  Shortness of breath 083-  Pounding in your chest

084-  Other symptoms when working under these conditions in the past?

085- If yes, please describe: \_\_\_\_\_

\*N = Non-resistant to oil: filter-mask used in workplaces free of oil aerosols

R = Resistant to oil: filter-mask intended for filtering any particulate including any oil-based particulate; R series has time-use limitations (usually 1 shift)

P = Oil-Proof: filter-mask intended for filtering any particulates including any oil-based liquids; P series does not have time-use limitations.

YES  086  NO

At work or at home have you ever been or do you expect to be exposed to:

087-  Hazardous solvents; 088-  Hazardous airborne chemicals (e.g., gases, fumes or dust)

089-  Skin contact with hazardous chemicals 090- If yes, please list chemicals:

\_\_\_\_\_

Please provide the following information for each toxic substance that you will be exposed to (per shift) while using a respirator:

TOXIC SUBSTANCE (print first 15 characters)	Est. max. exp. level	Units <sup>1</sup>	Hrs.
091 <input type="text"/>	092 <input type="text"/>	093 <input type="text"/>	094 <input type="text"/>
095 <input type="text"/>	096 <input type="text"/>	097 <input type="text"/>	098 <input type="text"/>
099 <input type="text"/>	100 <input type="text"/>	101 <input type="text"/>	102 <input type="text"/>

<sup>1</sup> Use the following key to indicate Units of Measure: A = ppm (parts per million); B = mg/m<sup>3</sup>; C = μg/m<sup>3</sup>

YES  103  NO

Are there other toxic substances that you will be exposed to while using respirator?

104- If yes, please list: \_\_\_\_\_

105

Have you ever worked or do you expect to work specifically with any of the materials or under any of the conditions listed? If yes, please indicate the specific materials/conditions below.

106-  Asbestos 107-  Silica (e.g., in sandblasting)

108-  Tungsten/cobalt (e.g., grinding or welding this material) 109-  Beryllium

110-  Aluminum 111-  Coal (e.g., mining) 112-  Iron 113-  Tin

114-  Dusty environments 115-  Confined space 116-  Life-threatening gases (IDLH)

117- Any other hazardous exposures?  Yes  No 118- If yes, please list: \_\_\_\_\_

\_\_\_\_\_

TOBACCO USE SECTION

YES  119  NO

Do you currently smoke tobacco, or have you smoked tobacco in the last month?

If yes, please indicate type: 120-  Cigarettes 121-  Cigars 122-  Pipe

123

Have you ever smoked/used tobacco products?

If yes, please indicate amount, duration and quit date (if applicable) for each type used:

	Amount	Years of use	Quit date
124- <input checked="" type="checkbox"/> Cigarettes	125- <input type="text"/> <input type="text"/> pks/day	126- <input type="text"/> <input type="text"/>	127- <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Year
128- <input checked="" type="checkbox"/> Cigars	129- <input type="text"/> <input type="text"/> /day	130- <input type="text"/> <input type="text"/>	131- <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Year
132- <input checked="" type="checkbox"/> Pipe	133- <input type="text"/> <input type="text"/> bwls/day	134- <input type="text"/> <input type="text"/>	135- <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Year
136- <input checked="" type="checkbox"/> Smokeless tobacco	137- <input type="text"/> <input type="text"/> oz./day	138- <input type="text"/> <input type="text"/>	139- <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Year

## GENERAL MEDICAL SECTION

YES NO

 140 

Are you taking any medication for breathing problems, heart trouble, blood pressure, seizures? (This includes ALL prescription drugs, inhalers, patches, etc., even if use is occasional.)

141- If yes, please list: \_\_\_\_\_

 142 

Are you taking any other prescription or "over the counter" medicines on a daily or regular basis.

143- If yes, please list: \_\_\_\_\_

• For each condition with YES response, please note date of diagnosis, current status, and any current treatment. •

 144 

Are you currently under a doctor's care for any medical condition?

145- If yes, please specify condition(s): \_\_\_\_\_

Have you ever had or do you now have any of the following:

YES NO

(If yes, indicate date of diagnosis, current status and treatment.)

 146 

Claustrophobia 147-  With respirator use 148- \_\_\_\_\_

 149 

Skin disorders: 150-  Eczema 151-  Other (Please specify.) \_\_\_\_\_

 152 

Facial injury or deformity (including nasal septum) 153- \_\_\_\_\_

 154 

Dentures or removable dental appliance 155- \_\_\_\_\_

 156 

Problems with sense of smell/Trouble smelling odors 157- \_\_\_\_\_

 158 

Ear/Hearing problems: 159-  Injury 160-  Difficulty hearing 161-  Hearing aid  
162-  Ruptured/perforated eardrum (163-  resolved, 164-  unresolved, 165-  unknown)

166-  Any other ear/hearing problem (Please specify.) \_\_\_\_\_

 167 

Eye/vision problems: 168-  Eyeglasses 169-  Contact lenses 170-  Color blind

171-  Lost vision in either eye (172-  temporarily 173-  permanently)

174-  Any other eye or vision problem (Please specify.) \_\_\_\_\_

 175 

Musculoskeletal problems 176-  Back injury 177-  Back pain

178-  Weakness in any arm, hand, leg, or foot

179-  Pain or stiffness when leaning forward or backward at the waist

180-  Difficulty fully moving arms or legs 181-  Difficulty fully moving head up or down

182-  Difficulty fully moving head side to side 183-  Difficulty bending at knees

184-  Difficulty squatting to the ground

185-  Difficulty climbing a flight of stairs or a ladder while carrying more than 25 lbs.

186-  Any other muscle or skeletal problem that interferes with using a respirator:

 187 

Neuromuscular disease 188-  Muscular dystrophy 189-  Myasthenia gravis

190-  ALS (amyotrophic lateral sclerosis/Lou Gehrig's Disease) 191- If yes, describe extent of weakness: \_\_\_\_\_

 192 

Epilepsy/seizure disorder • If yes, enter date of last seizure 193-        
Month Year

and estimated number of seizures per year 194-

## GENERAL MEDICAL SECTION (cont'd)

YES NO

 195 

Cancer • 196- If yes, please describe origin, treatment, status: \_\_\_\_\_

\_\_\_\_\_ 197- Lungs affected?  Yes  No 198 Surgery • 199-  Facial 200-  Neck 201-  Chest 202-  Heart 203-  Lung204-  Back 205-  Other \_\_\_\_\_

206- If yes, indicate date, type and results: \_\_\_\_\_

## RESPIRATORY SECTION

• For each condition with YES response, please note date of diagnosis, current status, and any current treatment. •  
 Have you ever had or do you now have any of the following:

YES NO

 207 

Inhalant allergies (seasonal, animal dander, dusts, etc.) 208- \_\_\_\_\_

\_\_\_\_\_ 209- Interferes with breathing?  Yes  No 210 

All other allergies (including medications, foods, insect bites) 211- \_\_\_\_\_

\_\_\_\_\_ 212- Interferes with breathing?  Yes  No 213 

Abnormal chest x-ray 214- \_\_\_\_\_

 215 Asthma 216-  Childhood only 217-  Current • 218- If yes, describe onset, last episode and frequency: \_\_\_\_\_ 219 Wheezing or asthma-like symptoms 220-  Interferes with job 221-  On treatment/inhaler

222- \_\_\_\_\_

 223 

Bronchial infections which occur yearly or more frequently 224- \_\_\_\_\_

 225 Bronchitis/Cough 226-  Occasional (a.m.) 227-  Moderate (4-6 times/day)228-  Severe (daily over period of 3 mo. or more) 229-  Mostly when lying down

230- \_\_\_\_\_

 231 Sputum/Phlegm with coughing 232-  Occasional (a.m.) 233-  Moderate (2x/day or 4x/wk)234-  Severe (daily over period of 3 mo. or more) 235- \_\_\_\_\_ 236 

Coughing up blood 237- \_\_\_\_\_

 238 

Chest pain when breathing deeply 239- \_\_\_\_\_

 240 

Collapsed lung/pneumothorax 241- \_\_\_\_\_

 242 Any chest injuries 243-  Broken ribs 244-  Other (Please specify.) 245- \_\_\_\_\_ 246 

Emphysema 247- \_\_\_\_\_

 248 

Silicosis • 249- If yes, please indicate exposure date, diagnosis date and method \_\_\_\_\_

 250 Pneumonia 251-  Remote past only 252-  Recent/CurrentIf yes, please indicate approximate date of last episode 253-        
Month Year

## RESPIRATORY SECTION (cont'd)

YES NO

254  Asbestosis • 255- If yes, please indicate exposure date, diagnosis date and method of diagnosis: \_\_\_\_\_  
\_\_\_\_\_

256  Tuberculosis 257-  Positive skin test 258-  Treated 259-  Untreated  
260- \_\_\_\_\_

261  Shortness of breath 262-  Climbing two flights of stairs 263-  Climbing one flight of stairs  
264-  Walking on level ground at ordinary pace 265- Estimated distance in feet     
266-  Walking on slight incline/hill 267-  Walking fast 268-  Washing or dressing self  
269-  Interferes with job 270- \_\_\_\_\_

271  Any other lung problem you have been told about or other symptoms you think may be related to  
lung problems? 272- \_\_\_\_\_

273  Current symptoms related to workplace only 274- \_\_\_\_\_

275  Is WorkHealth permitted to inform employer of response to previous question ONLY?

276  Have you had a chest x-ray in the past 6 months? 277- If yes, where? \_\_\_\_\_

## CARDIOVASCULAR SECTION

• For each condition with YES response, please note date of diagnosis, current status, and any current treatment. •  
Have you ever had or do you now have any of the following:

YES NO

278  Chest symptoms Type: 279-  Pain 280-  Pressure 281-  Tightness  
Age at onset 282-    
Episode frequency 283-  Daily 284-  Weekly 285-  Monthly  
Episode intensity 286-  Mild 287-  Moderate 288-  Severe  
Episode duration 289-  Few seconds 290-  Few minutes 291-  Several minutes  
Associated with 292-  Activity 293-  Interferes with/Associated with job  
Accompanied by 294-  Sweating 295-  Shortness of breath  
296- \_\_\_\_\_

297  Heartburn or indigestion 298-  Acid reflux 299-  Ulcer 300-  Unrelated to eating  
301- \_\_\_\_\_

302  Rheumatic heart disease/History of heart murmur 303-  Past only 304-  Current  
305- \_\_\_\_\_

306  Irregular heart beat/arrhythmia 307-  Heart skipping/missing a beat 308- \_\_\_\_\_

309  Conditions 310-  Heart attack 311- \_\_\_\_\_  
312-  Angina 313- \_\_\_\_\_  
314-  Heart failure 315- \_\_\_\_\_

CARDIOVASCULAR SECTION (cont'd)

YES NO

316

Procedures (Please indicate dates and results if applicable:)

317-  Abnormal electrocardiogram (ECG/EKG) 318- \_\_\_\_\_

319-  Abnormal cardiac stress test 320- \_\_\_\_\_

321-  Heart catheterization 322- \_\_\_\_\_

323-  Balloon catheterization 324- \_\_\_\_\_

325-  Angioplasty 326- \_\_\_\_\_

327-  Stent 328- \_\_\_\_\_

329

Stroke/CVA 330-  Permanent weakness 331-  Interferes with job 332- \_\_\_\_\_

333

Hypertension/High blood pressure 334-  Treatment for 5 years or more 335- \_\_\_\_\_

336

Swelling in legs or feet (not caused by walking) 337- \_\_\_\_\_

338

Diabetes 339-  Treatment for 5 years or more 340-  Insulin dependent 341- \_\_\_\_\_

342

Any other heart problem you have been told about or other symptoms you think may be related to heart or circulatory problems? 343- \_\_\_\_\_

344

ANY ADDITIONAL COMMENTS: 345- \_\_\_\_\_

346

"I would like to talk to the health care professional who will review this questionnaire about my answers to this questionnaire."

347

"I have been informed that I may contact WorkHealth at 1-614-566-2502 to speak with the health care professional who will be reviewing this questionnaire."

348

"I understand and have truthfully responded to all of the previous questions."

Employee Signature \_\_\_\_\_

349- Date

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year			

IF PRELIMINARY CLINICAL ASSESSMENT DATA AVAILABLE, PLEASE INDICATE FINDINGS BELOW.

350- Date of assessment

Month Day Year

351- Provider Code

Blood Pressure(s): 352-  /

353- Was large cuff used?  Yes  No

354-  /

355- Was large cuff used?  Yes  No

356-  /

357- Was large cuff used?  Yes  No

358- Pulse :

359-  Resting  Post-exercise

360- Measured Ht.  ft.  in.

361- Measured Wt.  lbs. 362- Other (type & findings): \_\_\_\_\_

363- Other (type & findings): \_\_\_\_\_

Assessment performed by: 364-  Employee him/herself 365-  Other (see below)

If other, indicate name 366-  \_\_\_\_\_ and title 367-  \_\_\_\_\_