Your Hospital's Logo Here

NOISE EXPOSURE & RESPIRATOR USE
OCCUPATIONAL SURVEILLANCE

Please complete this confidential questionnaire by placing a check mark in the appropriate spaces or by printing other information when required . (Use black or blue ink).

IDENTIFICATION

TODAY'S DATE:	LAST NAME:	FIRST (No nicknames)	MIDDLE

SEX: ☐ MALE ☐ FEMALE	SOCIAL SECURITY NO: - -	BIRTHDATE: - -

AGENCY / DEPT:	BLDG / ROOM	BUSINESS PHONE:

JOB TITLE:	SUPERVISOR	SUPERVISOR'S PHONE:

YOUR MAILING ADDRESS:	CITY / STATE	ZIP	HOME PHONE:

MEDICATIONS

List **ALL** medications (including prescription, vitamins, and herbal preparations) you currently take:

HOSPITALIZATIONS & SURGERIES

List **ALL** hospitalizations, surgeries, and the years they occurred:

LEISURE ACTIVITIES

(1) In which of the following hobbies / activities do you participate?

☐ Auto / Boat Repair ☐ Ceramics / Pottery ☐ Guns / Hunting ☐ Other (Specify) _____

☐ Power Tool Usage ☐ Refinishing _____

(2) Do you use safety equipment when you engage in this activity? ☐ YES ☐ NO

PAST MEDICAL HISTORY: Check any of the following conditions that you have now or have ever had:

EAR:	DECREASED HEARING	☐ YES	☐ NO	RINGING / BUZZING	☐ YES	☐ NO
	HEARING LOSS	☐ YES	☐ NO	RUPTURED EAR DRUM	☐ YES	☐ NO
	OTHER EAR INJURY	☐ YES	☐ NO	OTHER (Explain):		
HEART:	CHEST PAIN / TIGHTNESS	☐ YES	☐ NO	IRREGULAR HEART BEAT	☐ YES	☐ NO
	HEART ATTACK	☐ YES	☐ NO	STROKE	☐ YES	☐ NO
	HEART MURMUR	☐ YES	☐ NO	SWELLING OF LEGS / FEET	☐ YES	☐ NO
	HIGH BLOOD PRESSURE	☐ YES	☐ NO	OTHER (Explain):		
LUNG:	ASBESTOSIS	☐ YES	☐ NO	PNEUMOTHORAX (COLLAPSED LUNG)	☐ YES	☐ NO
	CHRONIC BRONCHITIS	☐ YES	☐ NO	LUNG CANCER	☐ YES	☐ NO
	EMPHYSEMA	☐ YES	☐ NO	BROKEN RIBS	☐ YES	☐ NO
	PNEUMONIA	☐ YES	☐ NO	ANY CHEST INJURIES / SURGERIES	☐ YES	☐ NO
	TUBERCULOSIS	☐ YES	☐ NO	COUGHING UP BLOOD	☐ YES	☐ NO
	SILICOSIS	☐ YES	☐ NO	WHEEZING	☐ YES	☐ NO
OTHER	EYE IRRITATION	☐ YES	☐ NO	GENERAL WEAKNESS	☐ YES	☐ NO
	SKIN ALLERGIES / RASHES	☐ YES	☐ NO	CLAUSTROPHOBIA	☐ YES	☐ NO
	ANXIETY	☐ YES	☐ NO	OTHER (Explain):		

HEARING QUESTIONNAIRE

Have you had prior military service?	☐ YES	☐ NO	Have you had noise exposure within the last 14 hours?	☐ YES ☐ NO
Have you had previous ear surgery?	☐ YES	☐ NO	Do you wear hearing protection?	☐ YES ☐ NO
Have you had recurrent ear infections?	☐ YES	☐ NO	If "YES", what type?	☐ Foam ☐ Pre-Molds / Plugs ☐ Ear Muffins
Do you have a known hearing loss?	☐ YES	☐ NO		

RESPIRATOR QUESTIONNAIRE

Indicate the type of respirator you use:	☐ Cartridge	☐ Air Supply	☐ SCBA	☐ Filter / Mask	Wear contact lenses?	☐ Y	☐ N
How often do you use a respirator?	☐ Daily	☐ 1x-4x per Week	☐ 1x-4x per Month	☐ 1x-4x per Year	Previous respirator use?	☐ Y	☐ N
Hours of use in a typical day:	☐ < 2 Hours	☐ 2-4 Hours	☐ 4-6 Hours	☐ > 6 Hours	Difficulty with previous respirator use?	☐ Y	☐ N
Usual effort while wearing respirator?	☐ Light	☐ Moderate	☐ Heavy				
Hazards present during respirator use:	☐ High Altitude	☐ Temperature Extremes	☐ Confined Spaces		Wear glasses?	☐ Y	☐ N

SOCIAL HISTORY:

(1) Have you ever used tobacco? ☐ YES ☐ NO

(a) If "YES", when? ☐ CURRENT ☐ PAST (Years since quitting?) _____

(b) If "YES", what type? ☐ CIGARETTES ☐ PIPE / CIGAR

_____ Amount Per Day _____ For How Many Years

(2) What is your average alcohol consumption in a week? _____ Drinks (1 drink = 12 oz. Beer, 1 Glass Wine or 1.5 Oz. Liquor)

(3) How often do you drink alcohol? ☐ WEEKDAYS ☐ WEEKENDS ☐ BOTH

EXAMINER'S COMMENTS (List exposure # with appropriate comment):

HEARING
☐ Normal
☐ Abnormal

HEIGHT:	WEIGHT:	TEMP:	RESP:	BP:	PULSE:

DRUG ALLERGY:	GENERAL HEALTH:

	Normal	Abnormal	Not Done	Findings
E.E.N.T.	☐	☐	☐	
Heart	☐	☐	☐	
Lungs	☐	☐	☐	
Extremities	☐	☐	☐	
Vascular-Pulses	☐	☐	☐	

ASSESSMENT / REFERRAL PLAN **Comments**

		No Referral	Referred	
			Routine	Urgent
(1)		☐	☐	☐
		☐	☐	☐
(2)		☐	☐	☐
		☐	☐	☐
(3)		☐	☐	☐

RECOMMENDATIONS / EDUCATION SUMMARY The following topics and recommendations marked with a 🗐 were discussed with the employee.

☐ Protective Equipment

- ☐ Hearing
- ☐ Safety glasses
- ☐ Respirator use
- ☐ Gloves/Skin protection
- ☐ Seat belts
- ☐ Other _____

- ☐ Smoking cessation
- ☐ Reduce or stop alcohol consumption
- ☐ Participate in regular cancer screening
- ☐ Universal Precautions
- ☐ Avoid sun exposure/Use sun block
- ☐ Other _____

EXAMINER'S SIGNATURE:	EXAMINER'S PRINTED NAME:	DATE:

EMPLOYEE'S SIGNATURE:	DATE:

APPLICABLE JOB TITLES

FACILITIES & SECURITY DEPARTMENT

- Crew Foreman, Crew
- General Foreman, Construction
- General Foreman, Bldg & Grounds
- Operator, Road Sweeper
- Facilities Worker
- Materials Handler
- Facilities Mechanic

WASTE WATER SERVICES

- Operator 1 & 2, WWT
- Foreman, WWT
- Laborer, WWT