Your Hospital's Logo Here

RESPIRATOR USE & HAZMAT EXPOSURE
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 ☐ Other (Specify) _____
☐ Gardening ☐ 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:

ABDOMEN	CHRONIC STOMACH PAIN	☐ YES	☐ NO
	DIARRHEA	☐ YES	☐ NO
	HEPATITIS	☐ YES	☐ NO
	HERNIA	☐ YES	☐ NO
	NAUSEA / VOMITING	☐ YES	☐ NO
	OTHER (Explain):		
BLOOD	ANEMIA	☐ YES	☐ NO
	BLEEDING DISORDER	☐ YES	☐ NO
	OTHER (Explain):		
HEARING	DECREASED HEARING	☐ YES	☐ NO
	HEARING LOSS	☐ YES	☐ NO
	OTHER EAR INJURY	☐ YES	☐ NO
	RINGING / BUZZING	☐ YES	☐ NO
	RUPTURED EAR DRUM	☐ YES	☐ NO
	OTHER (Explain):		
HEART	CHEST PAIN / TIGHTNESS	☐ YES	☐ NO
	HEART ATTACK	☐ YES	☐ NO
	HEART MURMUR	☐ YES	☐ NO
	HIGH BLOOD PRESSURE	☐ YES	☐ NO
	IRREGULAR HEART BEAT	☐ YES	☐ NO
	STROKE	☐ YES	☐ NO
	SWELLING OF LEGS / FEET	☐ YES	☐ NO
	OTHER (Explain):		
LUNGS	ASBESTOSIS	☐ YES	☐ NO
	CHRONIC BRONCHITIS	☐ YES	☐ NO
	EMPHYSEMA	☐ YES	☐ NO
	PNEUMONIA	☐ YES	☐ NO
	TUBERCULOSIS	☐ YES	☐ NO
	SILICOSIS	☐ YES	☐ NO
	EYE IRRITATION	☐ YES	☐ NO
	SKIN ALLERGIES / RASHES	☐ YES	☐ NO
	PNEUMOTHORAX (COLLAPSED LUNG)	☐ YES	☐ NO
	LUNG CANCER	☐ YES	☐ NO
	BROKEN RIBS	☐ YES	☐ NO
	ANY CHEST INJURIES / SURGERIES	☐ YES	☐ NO
	COUGHING UP BLOOD	☐ YES	☐ NO
	WHEEZING	☐ YES	☐ NO
	OTHER (Explain):		
MENTAL	ANXIETY	☐ YES	☐ NO
	CLAUSTROPHOBIA	☐ YES	☐ NO
	DEPRESSION	☐ YES	☐ NO
MENTAL (cont)	MEMORY LOSS	☐ YES	☐ NO
	PHOBIAS	☐ YES	☐ NO
	OTHER (Explain):		
METABOLISM	DIABETES	☐ YES	☐ NO
	LOSS OF APPETITE	☐ YES	☐ NO
	THYROID DISORDER	☐ YES	☐ NO
	Unexplained WEIGHT GAIN / LOSS	☐ YES	☐ NO
	OTHER (Explain):		
NECK	CHRONIC SORE THROATS	☐ YES	☐ NO
	DIFFICULTY SWALLOWING	☐ YES	☐ NO
	SWOLLEN / TENDER NECK	☐ YES	☐ NO
	OTHER (Explain):		
NEURO	CHRONIC HEADACHE	☐ YES	☐ NO
	CONFUSION	☐ YES	☐ NO
	CONVULSIONS	☐ YES	☐ NO
	DECREASED ALERTNESS	☐ YES	☐ NO
	DIZZINESS	☐ YES	☐ NO
	FAINTING	☐ YES	☐ NO
	GENERAL WEAKNESS	☐ YES	☐ NO
	INJURY	☐ YES	☐ NO
	LOSS OF CONSCIOUSNESS	☐ YES	☐ NO
	MIGRAINES	☐ YES	☐ NO
	NUMBNESS / WEAKNESS	☐ YES	☐ NO
	TREMORS	☐ YES	☐ NO
	UNEXPLAINED SLEEPINESS	☐ YES	☐ NO
	OTHER (Explain):		
NOSE	CHRONIC NOSE BLEEDS	☐ YES	☐ NO
	SINUS DISORDERS	☐ YES	☐ NO
	OTHER (Explain):		
SKIN	BRUISING	☐ YES	☐ NO
	JAUNDICE / YELLOWNESS	☐ YES	☐ NO
	RASH	☐ YES	☐ NO
	OTHER (Explain):		
URINE	DARK URINE	☐ YES	☐ NO
	KIDNEY DISORDERS	☐ YES	☐ NO
	OTHER (Explain):		
VISION	BLURRED VISION	☐ YES	☐ NO
	DECREASED FAR VISION	☐ YES	☐ NO
	DECREASED NEAR VISION	☐ YES	☐ NO
	VISION IN ONE EYE ONLY	☐ YES	☐ NO
	OTHER (Explain):		

EXAMINER'S COMMENTS (All positive responses above should be discussed here):

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			Wear glasses?	☐ Y	☐ N
Hazards present during respirator use:	☐ High Altitude	☐ Temperature Extremes		☐ Confined Spaces				

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

OCCUPATIONAL HISTORY

Briefly describe your current job's activities

How long have you been doing this type of work? ..... YRS

Have you ever been off work more than a day due to a work related illness / injury? ☐ YES (Specify) _____ ☐ NO

EXPOSURE HISTORY

This section provides the examiner with information regarding your history of exposure to hazardous substances. Complete each item based on your personal experiences over the past year. When necessary, additional hazards may be added at the end of this insert.

Exposure Type	Frequency of Exposure				Length of Exposure	Symptoms from Exposure	Protection used with Exposure
Instructions: Check chemicals or work conditions that apply to you	Often	Sometimes	Rarely	Seasonal	Instructions: Usual # of hours exposed (hr./d)	Instructions: List symptoms you feel may be associated with exposure	Instructions: % time you wear protective equipment with this exposure i.e., 10%, 25%, 50%, etc.
DUSTS OR FUMES - Usual Route of Exposure: Inhalation							
1. Asbestos							
2. Cement Dust							
3. Fiberglass							
4. Lead							
5. Welding Fumes							
6. Other dust (Specify)							
SOLVENTS- Usual Route of Exposure: Inhalation and Skin							
7. Alcohol							
8. Formaldehyde							
9. Degreasers (specify)							
10. PCBs							
11. Pesticides							
12. Other Chem. (Specify)							
OTHER POTENTIAL EXPOSURES OR WORK TASKS							
13. HazMat/Superfund Sites							
14. Other exposures (Specify)							

** **Often** = Almost Daily **Sometimes** = 1-3 times a month **Rarely** = less than monthly **Seasonally** = concentrated exposure during a predictable time period

NAME	SOCIAL SECURITY # - -	DATE:

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

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

DRUG ALLERGY:	GENERAL HEALTH:

VISION ☐ GLASSES ☐ CONTACTS

	Uncorrected		Corrected	
	Right	**Left**	**Right**	**Left**
Near	20 /	20 /	20 /	20 /
Far	20 /	20 /	20 /	20 /

EKG	**LABS**	**PFT**
☐ Normal ☐ Abnormal ☐ Not Done	☐ Yes ☐ No	☐ Normal ☐ Abnormal ☐ Not Done

	Normal	Abnormal	Not Done	Findings
Head/Neck	☐	☐	☐	
E.E.N.T.	☐	☐	☐	
Heart	☐	☐	☐	
Lungs	☐	☐	☐	
Abdomen	☐	☐	☐	
Muskuloskeletal	☐	☐	☐	
Extremities	☐	☐	☐	
Vascular-Pulses	☐	☐	☐	
Neurological	☐	☐	☐	
Skin	☐	☐	☐	
Lymphatics	☐	☐	☐	

ASSESSMENT / REFERRAL PLAN

	Comments	No Referral	Referred	
			Routine	Urgent
(1)		☐	☐	☐
(2)		☐	☐	☐
(3)		☐	☐	☐
(4)		☐	☐	☐
(5)		☐	☐	☐

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

☐ Protective Equipment

- ☐ 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:

I GIVE MY CONSENT FOR A PHYSICAL EXAMINATION THAT MAY INCLUDE TESTS & PROCEDURES DEEMED NECESSARY

EMPLOYEE'S SIGNATURE:	DATE:

APPLICABLE JOB TITLES