

CONFIDENTIAL

# PRE-PLACEMENT SUPPLEMENTAL MEDICAL HISTORY QUESTIONNAIRE FOR RESPIRATOR USERS

## OCCUPATIONAL HEALTH PROGRAMS COUNTY OF LOS ANGELES

The County position that you are seeking may require that you use respiratory protection for performing certain tasks. Cal/OSHA regulations require that the County make specific medical inquiries to assess whether you can safely use a respirator. Therefore, in addition to the standard medical history questionnaire, it is necessary for you to complete this supplemental medical history form.

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

A "Yes" or "No" must be checked for each item. Check "Yes" for any of the following conditions which you now have or have ever had. Do not leave any blanks. You must explain all "Yes" answers regarding medical conditions or symptoms on page 4 of your primary medical history questionnaire.

S1. During the last year, have you used any type of respiratory protection, such as a self-contained breathing apparatus (SCBA), cartridge or dist mask? Yes \_\_\_ No \_\_\_

How often did you use the respirator? \_\_\_\_\_

S2. If you have ever used a respirator, have you ever had any of the following problems?

- Yes / No a. Eye irritation
- Yes / No b. Skin allergies or rashes
- Yes / No c. Anxiety
- Yes / No d. General weakness or fatigue
- Yes / No e. Any other problem that interferes with your use of a respirator

S3. Check the type of respirator you will be using or have used in the past year (you can check more than one category):

- \_\_\_ N, R, or P disposable respirator (filter-mask, non-cartridge type only)
- \_\_\_ Half- or full-face piece cartridge type
- \_\_\_ Powered-air purifying, supplied-air
- \_\_\_ Self-contained breathing apparatus

S4. Have you ever had any of the following conditions?

- Yes / No Allergic reactions that interfere with your breathing
- Yes / No Trouble smelling odors
- Yes / No Razor Bumps (Pseudofolliculitis Barbae)
- Yes / No Pneumonia
- Yes / No Asbestosis
- Yes / No Silicosis
- Yes / No Pneumothorax (collapsed lungs)
- Yes / No Lung cancer
- Yes / No Broken ribs
- Yes / No Any chest injuries or surgeries
- Yes / No Any other lung problem that you have been told about

S5. Do you currently have any of the following symptoms of pulmonary or lung illness? Yes / No

- Yes / No Shortness of breath while walking at your own pace on level ground
- Yes / No Shortness of breath when walking fast on level ground or walking up a slight hill or incline or after climbing two flights of stairs
- Yes / No Have to stop for breath when walking at your own pace on level ground
- Yes / No Shortness of breath when washing or dressing yourself
- Yes / No Shortness of breath that interferes with your job
- Yes / No Coughing that produces phlegm (thick sputum)
- Yes / No Coughing that wakes you early in the morning
- Yes / No Coughing that occurs mostly when you are lying down
- Yes / No Coughing up blood in the last month
- Yes / No Wheezing that interferes with your job
- Yes / No Chest pain when you breathe deeply
- Yes / No Any other symptoms that you think may be related to lung problems

S6. Have you ever had any of the following cardiovascular or heart problems?

- Yes / No Angina
- Yes / No Pain or tightness in your chest during physical activity
- Yes / No Pain or tightness in your chest that interferes with your job
- Yes / No In the past two years, have you noticed your heart skipping or missing a beat
- Yes / No Heartburn or indigestion that is not related to eating?
- Yes / No Any other heart problem that you have been told about
- Yes / No Any other symptoms that you think may be related to heart or circulation problems

S7. Have you ever lost vision in either eye (temporarily or permanently)? Yes / No

S8. Do you currently own or wear a hearing aid? Yes / No

S9. Do you have color blindness? Yes / No

S10. Do you currently have any of the following musculoskeletal problems?

- Yes / No Weakness in any of your arms, hands, legs or feet
- Yes / No Difficulty fully moving your arms and legs
- Yes / No Pain or stiffness when you lean forward or backward at the waist
- Yes / No Difficulty fully moving your head up or down
- Yes / No Difficulty fully moving head side to side
- Yes / No Difficulty bending at the knees
- Yes / No Difficulty squatting to the ground
- Yes / No Climbing a flight of stairs or a ladder carrying more than 25 lbs.
- Yes / No Any other muscle or skeletal problem that interferes with using a respirator

S11. Do you have any medical conditions for which you regularly see a doctor? Yes / No

Signature \_\_\_\_\_ Date \_\_\_\_\_