COUNTY OF LOS ANGELES
Department of Human Resources | Occupational Health Programs
Pre-Employment/Post-Offer Medical Examinations
Phone: 213-738-2187 | Fax: 213-784-1713

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Section 1. *The County position you are seeking may require that you use respirator protection for performing certain tasks. California/OSHA regulations require the County ensure that 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 (last, first, middle initial): _____

Gender: ☐ Male ☐ Female Height: _____ feet _____ inches Weight: _____ pounds

Date of birth: _____ Last four digits of Social Security number: _____

Agency/department and job title: _____

Phone number where you can be reached by the healthcare professional who reviews this questionnaire (include area code): _____

The best time to reach you at this number: _____

Check the type(s) of respirator you will use:

☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only)

☐ SCBA respirator (self-contained, breathing apparatus)

☐ Other type (half or full-face type, powered-air purifying, supplied-air)

Have you ever worn a respirator before? ☐ Yes ☐ No ☐ Unsure

If "Yes," what type(s)? _____

Section 2. *These questions must be answered by every candidate and employee who has been selected to use any type of respirator. Be as accurate as possible, and do not leave any answers blank.*

1. Do you currently smoke tobacco, or have you smoked tobacco in the past month? ☐ Yes ☐ No

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

   Seizures (fits) ☐ Yes ☐ No

   Diabetes (sugar disease) ☐ Yes ☐ No

   Allergic reactions that interfere with your breathing ☐ Yes ☐ No

   Claustrophobia (fear of closed-in places) ☐ Yes ☐ No

   Trouble smelling odors ☐ Yes ☐ No

3. Have you ever had any of the following pulmonary or lung problems?

Asbestosis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Chronic bronchitis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Silicosis	☐ Yes	☐ No
Pneumothorax (collapsed lung)	☐ Yes	☐ No
Lung cancer	☐ Yes	☐ No
Broken ribs	☐ Yes	☐ No
Any chest injuries or surgeries	☐ Yes	☐ No
Any other lung problem that you've been told about	☐ Yes	☐ No

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

Shortness of breath	☐ Yes	☐ No
Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐ Yes	☐ No
Shortness of breath when walking with other people at an ordinary pace on level ground	☐ 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 past month	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Wheezing that interferes with your job	☐ Yes	☐ No
Chest pain when you breathe deeply	☐ Yes	☐ No
Any other symptoms you think may be related to lung problems	☐ Yes	☐ No

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

Heart attack	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Angina	☐ Yes	☐ No
Heart failure	☐ Yes	☐ No

Swelling in your legs or feet (not caused by walking) ☐ Yes ☐ No

Heart arrhythmia (heart beating irregularly) ☐ Yes ☐ No

High blood pressure ☐ Yes ☐ No

Any other heart problem you've been told about ☐ Yes ☐ No

6. Have you ever had any of the following cardiovascular or heart symptoms?

Frequent pain or tightness in your chest ☐ 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

Heart skipping or missing a beat (in past two years) ☐ Yes ☐ No

Heartburn or indigestion not related to eating ☐ Yes ☐ No

Any other symptoms that you think may be related to heart or circulation problems ☐ Yes ☐ No

7. Do you currently take medication for any of the following problems?

Breathing or lung problems ☐ Yes ☐ No

Heart trouble ☐ Yes ☐ No

Blood pressure ☐ Yes ☐ No

Seizures (fits) ☐ Yes ☐ No

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

☐ If you've never used a respirator, check here and go to question 9.

Eye irritation ☐ Yes ☐ No

Skin allergies or rashes ☐ Yes ☐ No

Anxiety ☐ Yes ☐ No

General weakness or fatigue ☐ Yes ☐ No

Any other problem that interferes with your use of a respirator ☐ Yes ☐ No

9. How often are you expected to use the respirator(s) (check all that apply)?

☐ Escape only (no rescue)

☐ Emergency rescue only

☐ Fewer than 5 hours per week

☐ Fewer than 2 hours per day

☐ 2 to 4 hours per day

☐ More than 4 hours per day

☐ Unknown

10. Work requiring respirator use is (check one): ☐ Light ☐ Moderate ☐ Heavy

Examples:
Light: Sitting while writing, performing light assembly work, and controlling machines
Moderate: Standing while nailing, transferring a 35-pound object at waist level, walking on a level surface at 2 mph
Heavy: Lifting 50 lbs from the floor to your waist, shoveling, standing while bricklaying

11. Do you normally have a beard, goatee, mustache, or other facial hair growth? ☐ Yes ☐ No

    If "Yes," does your facial hair come in contact with the seal of the respirator? ☐ Yes ☐ No

12. How much exercise (outside of work) do you get in a typical week? Please explain:

_____

_____

_____

Section 3. *Questions 13–16 must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.*

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

14. Do you currently have any of the following vision problems?

    Wear contact lenses ☐ Yes ☐ No

    Wear glasses ☐ Yes ☐ No

    Colorblind ☐ Yes ☐ No

    Any other eye or vision problem ☐ Yes ☐ No

    Have you ever had an injury to your ears, including a ruptured eardrum? ☐ Yes ☐ No

15. Do you currently have any of the following hearing problems?

    Difficulty hearing ☐ Yes ☐ No

    Wear a hearing aid ☐ Yes ☐ No

    Any other hearing or ear problem ☐ Yes ☐ No

    Have you ever had a back injury? ☐ Yes ☐ No

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

    Weakness in any of your arms, hands, legs, or feet ☐ Yes ☐ No

    Back pain ☐ Yes ☐ No

    Difficulty fully moving your arms and legs ☐ Yes ☐ No

    Pain and 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 your head side to side	☐ Yes	☐ No
Difficulty bending at your knees	☐ Yes	☐ No
Difficulty squatting to the ground	☐ Yes	☐ No
Difficulty climbing a flight of stairs or a ladder carrying more than 25 pounds	☐ Yes	☐ No
Any other muscle or skeletal problem that interferes with using a respirator	☐ Yes	☐ No

Applicant Certification: *I hereby certify that all of my statements and answers are true and complete. I understand that any misstatement of material fact may subject me to disqualification or dismissal and may cause forfeiture of all rights to employment.*

Applicant signature: _____ Date: _____

Physician instructions:

1. Review questionnaire responses and use this information in conjunction with your physical examination of the candidate to determine the candidate's ability to assume the position sought, with or without the need for work restrictions.
2. Maintain this questionnaire in your files. The County is not to receive this questionnaire.
3. Complete the Healthcare Provider's Findings Report on page 5 of the Health History Questionnaire.
4. Fax ONLY the Healthcare Provider's Findings Report to OHP at (213) 784-1713.

Physician comments/notes: _____

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DO <u>NOT</u> SEND THIS COMPLETED QUESTIONNAIRE TO THE COUNTY OF LOS ANGELES