

Required Procedures for Respiratory Protection Program

Chapter 296-842 WAC

Rule

WAC 296-842-22005

Use this medical questionnaire for medical evaluations

Use the medical questionnaire in Table 10 when conducting medical evaluations.



Note:

- You may use a physical exam instead of this questionnaire if the exam covers the same information as the questionnaire.
- You may use on-line questionnaires if the questions are the same and the requirements in WAC 296-842-14005 of this chapter are met.
- You may choose to send the questionnaire to the LHCP ahead of time, giving time to review it and add any necessary questions.
- The LHCP determines what questions to add to the questionnaire, if any; however, questions in Parts 1-3 may not be deleted or substantially altered.

Table 10 DOSH Medical Evaluation Questionnaire
<p>Employer Instructions:</p> <ul style="list-style-type: none">• You may use on-line questionnaires if the requirements in WAC 296-842-14005 are met.• You must tell your employee how to deliver or send the completed questionnaire to the health care provider you have selected.• You must not review employees' questionnaires.
<p>Health care provider's instructions:</p> <ul style="list-style-type: none">• Review the information in this questionnaire and any additional information provided to you by the employer.• You may add questions to this questionnaire at your discretion; However, questions in Parts 1-3 may not be deleted or substantially altered.• Follow-up evaluation is required for any positive response to questions 1-8 in Part 2, or questions 1-6 in Part 3. This might include: phone consultations to evaluate positive responses, medical tests, and diagnostic procedures.• When your evaluation is complete, send a copy of your written recommendation to the employer and employee.
<p>Employee information and instructions:</p> <ul style="list-style-type: none">• Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you.• Your employer or supervisor must not look at or review your answers at any time.

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Part 1-Employee Background Information
ALL employees must complete this part
Please print

1. Today's date: _____
2. Your name: _____
3. Your age (to nearest year): _____
4. Sex (circle one): Male / Female
5. Your height: _____ ft. _____ in.
6. Your weight: _____ lbs.
7. Your job title: _____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include Area Code): _____
9. The best time to call you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire? _____ Yes No
11. Check the type of respirator(s) you will be using:
 - a. _____ N, R, or P filtering facepiece respirator (for example, a dust mask, OR an N95 filtering facepiece respirator).
 - b. Check all that apply.
 Half mask Full facepiece mask Helmet hood Escape
 Non-powered cartridge or canister Powered air-purifying cartridge respirator (PAPR)
 Supplied-air or Air-line
 Self contained breathing apparatus (SCBA): Demand or Pressure demand
Other: _____
12. Have you previously worn a respirator? _____ Yes No
If "yes," describe what type(s): _____



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Part 2-General Health Information

ALL employees must complete this part - Please check "Yes" or "No"

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month? Yes No
2. Have you **ever had** any of the following conditions?
 - a. Seizures (fits): Yes No
 - b. Diabetes (sugar disease): Yes No
 - c. Allergic reactions that interfere with your breathing: Yes No
 - d. Claustrophobia (fear of closed-in places): Yes No
 - e. Trouble smelling odors: Yes No
3. Have you **ever had** any of the following pulmonary or lung problems?
 - a. Asbestosis: Yes No
 - b. Asthma: Yes No
 - c. Chronic bronchitis: Yes No
 - d. Emphysema: Yes No
 - e. Pneumonia: Yes No
 - f. Tuberculosis: Yes No
 - g. Silicosis: Yes No
 - h. Pneumothorax (collapsed lung): Yes No
 - i. Lung cancer: Yes No
 - j. Broken ribs: Yes No
 - k. Any chest injuries or surgeries: Yes No
 - l. Any other lung problem that you have been told about: Yes No
4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?
 - a. Shortness of breath: Yes No
 - b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes No
 - c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes No
 - d. Have to stop for breath when walking at your own pace on level ground: Yes No
 - e. Shortness of breath when washing or dressing yourself: Yes No
 - f. Shortness of breath that interferes with your job: Yes No
 - g. Coughing that produces phlegm (thick sputum): Yes No
 - h. Coughing that wakes you early in the morning: Yes No
 - i. Coughing that occurs mostly when you are lying down: Yes No
 - j. Coughing up blood in the last month: Yes No
 - k. Wheezing: Yes No
 - l. Wheezing that interferes with your job: Yes No
 - m. Chest pain when you breathe deeply: Yes No
 - n. Any other symptoms that you think may be related to lung problems: Yes No

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Part 2-General Health Information (Continued)

5. Have you **ever had** any of the following cardiovascular or heart problems?
- a. Heart attack: Yes No
- b. Stroke: Yes No
- c. Angina: Yes No
- d. Heart failure: Yes No
- e. Swelling in your legs or feet (not caused by walking): Yes No
- f. Heart arrhythmia (heart beating irregularly): Yes No
- g. High blood pressure: Yes No
- h. Any other heart problem that you have been told about: Yes No
6. Have you **ever had** any of the following cardiovascular or heart symptoms?
- a. Frequent pain or tightness in your chest: Yes No
- b. Pain or tightness in your chest during physical activity: Yes No
- c. Pain or tightness in your chest that interferes with your job: Yes No
- d. In the past 2 years, have you noticed your heart skipping or missing a beat: Yes No
- e. Heartburn or indigestion that isn't related to eating: Yes No
- f. 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?
- a. Breathing or lung problems: Yes No
- b. Heart trouble: Yes No
- c. Blood pressure: Yes No
- d. Seizures (fits): Yes No
8. If you have used a respirator, have you **ever had** any of the following problems? (If you have never used a respirator, check the following space and go to question 9:)
- 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? Yes No
9. Would you like to talk to the health care professional who will review this questionnaire about your answers? Yes No



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Part 3-Additional Questions for Users of Full-facepiece Respirators or SCBAs Please check "Yes" or "No"

1. Have you **ever lost** vision in either eye (temporarily or permanently): _____ Yes No
2. Do you **currently** have any of these vision problems?
 - a. Need to wear contact lenses: _____ Yes No
 - b. Need to wear glasses: _____ Yes No
 - c. Color blindness: _____ Yes No
 - d. Any other eye or vision problem: _____ Yes No
3. Have you **ever had** an injury to your ears, including a broken ear drum: _____ Yes No
4. Do you **currently** have any of these hearing problems?
 - a. Difficulty hearing: _____ Yes No
 - b. Need to wear a hearing aid: _____ Yes No
 - c. Any other hearing or ear problem: _____ Yes No
5. Have you **ever had** a back injury: _____ Yes No
6. Do you **currently** have any of the following musculoskeletal problems?
 - a. Weakness in any of your arms, hands, legs, or feet: _____ Yes No
 - b. Back pain: _____ Yes No
 - c. Difficulty fully moving your arms and legs: _____ Yes No
 - d. Pain or stiffness when you lean forward or backward at the waist: _____ Yes No
 - e. Difficulty fully moving your head up or down: _____ Yes No
 - f. Difficulty fully moving your head side to side: _____ Yes No
 - g. Difficulty bending at your knees: _____ Yes No
 - h. Difficulty squatting to the ground: _____ Yes No
 - i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: _____ Yes No
 - j. Any other muscle or skeletal problem that interferes with using a respirator: _____ Yes No

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Part 4-Discretionary Questions

Complete questions in this part **only if** your employer's health care provider says they are necessary

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen? _____ Yes No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you are working under these conditions: _____ Yes No

2. Have you ever been exposed (at work or home) to hazardous solvents, hazardous airborne chemicals (such as, gases, fumes, or dust), **or** have you come into skin contact with hazardous chemicals? _____ Yes No

If "yes," name the chemicals, if you know them:

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:
- | | | |
|--|------------------------------|-----------------------------|
| a. Asbestos? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| a. Silica (for example, in sandblasting)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Tungsten/cobalt (for example, grinding or welding this material)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Beryllium? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Aluminum? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Coal (for example, mining)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Iron? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Tin? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Dusty environments? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Any other hazardous exposures? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If "yes," describe these exposures:

4. List any second jobs or side businesses you have:

5. List your previous occupations:

6. List your current and previous hobbies:

7. Have you been in the military services? _____ Yes No
If "yes," were you exposed to biological or chemical agents (either in training or combat)? _____ Yes No

8. Have you ever worked on a HAZMAT team? _____ Yes No



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Part 4-Discretionary Questions (Continued)

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)? Yes No
If "yes," name the medications if you know them:

10. Will you be using any of the following items with your respirator(s)?
- a. HEPA Filters: Yes No
- b. Canisters (for example, gas masks): Yes No
- c. Cartridges: Yes No
11. How often are you expected to use the respirator(s)?
- a. Escape-only (no rescue): Yes No
- b. Emergency rescue only: Yes No
- c. Less than 5 hours **per week**: Yes No
- d. Less than 2 hours **per day**: Yes No
- e. 2 to 4 hours per day: Yes No
- f. Over 4 hours per day: Yes No
12. During the period you are using the respirator(s), is your work effort:
- a. **Light** (less than 200 kcal per hour): Yes No
If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of a 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.
- b. **Moderate** (200 to 350 kcal per hour): Yes No
If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

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.
- c. **Heavy** (above 350 kcal per hour): Yes No
If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of heavy work 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.)

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Part 4-Discretionary Questions (Continued)

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you are using your respirator: _____ Yes No

If "yes," describe this protective clothing and/or equipment:

14. Will you be working under hot conditions (temperature exceeding 77°F): _____ Yes No

15. Will you be working under humid conditions: _____ Yes No

16. Describe the work you will be doing while using your respirator(s):

17. Describe any special or hazardous conditions you might encounter when you are using your respirator(s) (for example, confined spaces, life-threatening gases):

18. Provide the following information, if you know it, for each toxic substance that you will be exposed to when you are using your respirator(s):

Name of the first toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the second toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the third toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

The name of any other toxic substances that you will be exposed to while using your respirator:

19. Describe any special responsibilities you will have while using your respirator(s) that may affect the safety and well being of others (for example, rescue, security).

