

CONFIDENTIAL MEDICAL EVALUATION AND WORKPLACE EXPOSURE QUESTIONNAIRE

Name (Last, First, M.I.)	PeopleSoft ID No. (See HR Rep. For No.)	Date of Birth
Home Address (Street)	City (Home)	State (Home)
Home Phone	Today's Date	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Job Title:	Wk. Phone:	E-mail:
PI/Supervisor	Student <input type="checkbox"/> Yes <input type="checkbox"/> No Dates Enrolled	
Department	College	

Please check one:

Respirator Use: ___ N-95 respirator; ___ all other respirator types.

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

All employees who are required to wear a **N-95 respirator** for protection against hazardous aerosols must complete this questionnaire. Current N-95 users should complete this questionnaire if there is a change in medical status, especially relating to heart and lung diseases, and seizures. For questions regarding a change in medical status, you may contact the Occupational Medicine program at 919-513-0277.

Part A. Section 1. (**Mandatory**) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Description of job activities: _____

2. A phone number where you can be reached by the health care professional who reviews this questionnaire (include area code) Work: _____ Cell: _____ Home: _____

3. The best time to phone you at this number: _____ A.M. _____ P.M.

4. Has your employer told you how to contact the health care professional who will review this questionnaire (check one): [] Yes [] No

5. Check the type of respirator you will use (you can check more than one category). If you're unsure, ask your supervisor.
- a. N-95 disposable respirator (filter-mask, non-cartridge type only).
 - b. Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
 - c. Extent of respirator usage:
 daily weekly less than once/week rarely only in emergency
 - d. Estimate length of time respirator will be worn in one day: _____
 - e. Date of most recent fit test: _____

6. List as completely as possible the materials, chemicals or substances with which you work. If you are unsure, ask your supervisor.

7. Do you wear or use any of the following protective equipment? If your are unsure, ask your supervisor.	YES	NO
Hearing protection		
Lab coat or protective clothing		
Gloves		
Safety glasses or goggles		
Safety Shoes		
Shoe covers or hair covers		
Exhaust hood or containment device		
Hard Hat		
Welding goggles		
Coveralls, including tyvek suits		
Please explain:		
Other:		

8. Do you work with or have significant exposure to any of the following?	YES	NO
Vapors or gases		
Dusts: () nuisance () other, explain:		
Pesticides		
Fumes or mists: () paint () welding () other, explain:		
Solvents (petroleum based, paint thinner, etc.)		
Metals, including welding, explain:		
Lead work: () lead dust () leadbased paint () lead fumes () other, explain:		
Biological agents		
Infectious agents		
Laboratory animals		
Loud noise		
Extreme heat or cold		
Vibration		
Radiation		
Stress which causes problems or symptoms at work or home		
Emergencies (please explain)		
Hazardous waste		
Unusually demanding hand or arm duties or postures		

PLEASE EXPLAIN ON BACK IF YOU CHECK "YES" TO ANY QUESTION

9. Have you ever:	YES	NO
a. Filed a compensation claim or received benefits for a occupational accident, injury or illness? Please explain:		
b. Been disabled or restricted for medical reasons?		
c. Changed jobs for health or safety reasons?		
d. Had difficulty wearing a respirator?		

Do you live near a plant, factory, dumpsite or other potential source of pollution? Yes No

Do you have any hobbies (such as painting, gardening, welding, woodworking, hairdressing or scuba diving) which involve exposure to chemicals or physical hazards? Yes No

Do you have more than one job? explain: Yes No

On the average, how many hours per week do you work? _____

10. Year of last tetanus booster: _____ Do not leave blank. (Booster recommended every 10 yrs. Please estimate year if you are unsure.)

Part A. Section 2. (Mandatory for respirator use) Questions 1 through 12 below must be answered by every employee who has been selected to use any type of respirator (please check "yes" or "no"). ***If you check "Yes" please explain in detail on the back. Include what was diagnosed, when it was diagnosed, and if the problem has been resolved or is on going.***

1. a. Do you *currently* smoke tobacco? If so, # packs per day: _____

b. Have you smoked tobacco in the past? If so, # of years: _____ # of packs per day: _____

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

PLEASE EXPLAIN ON BACK IF YOU CHECK "YES" TO ANY QUESTION.

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 (Coal Miner's Disease) 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've 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

PLEASE EXPLAIN ON BACK IF YOU CHECK "YES" TO ANY QUESTION

- j. Coughing up blood.....:..... []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 problem:..... []Yes []No
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've 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 two years, have you noticed your heart skipping or missing a beat:.... []Yes []No
- e. Heartburn or indigestion that is not related to eating:..... []Yes []No
- f. Any other symptoms that you think may be related to heart or circulation problems: []Yes []No

PLEASE EXPLAIN ON BACK IF YOU CHECK “” TO ANY QUESTION.

7. Do you currently take medication for any of the following problems? List medications taken for "Yes" answers to questions a through d.

- a. Breathing or lung problems: Yes No
- b. Heart trouble:..... Yes No
- c. Blood pressure:..... Yes No
- d. Seizures (fits):..... Yes No
- e. Other medications taken:.....

8. If you've used a respirator, have you ever had any of the following problems?
(If you've never used a respirator, check the following space and go to question 9):
 Never Used a Respirator

- 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. Have you ever lost vision in either eye (temporarily or permanently)? Yes No
Please explain: _____

10. Do you currently have any of the following vision conditions?

- a. Wear contact lenses:..... Yes No
- b. Wear glasses:..... Yes No
- c. Color blind:..... Yes No
- d. Any other eye or vision problem:..... Yes No

Please explain: _____

11. Have you ever had an injury to your ears, including a broken eardrum? If Yes, please explain: _____ Yes No

PLEASE EXPLAIN ON BACK IF YOU CHECK "YES" TO ANY QUESTION

12. Do you currently have any of the following hearing conditions? []Yes []No
- a. Difficulty hearing:..... []Yes []No
- b. Wear a hearing aid:..... []Yes []No
- c. Any other hearing or ear problem:..... []Yes []No

PLEASE EXPLAIN ON BACK IF YOU CHECK "YES" TO ANY QUESTION

I understand the questions above and have answered truthfully and fully to the best of my knowledge. I hereby permit the NCSU designated health care provider to review this confidential information and to provide to my employer a statement limited to my capability to wear a protective respirator, without any disclosure of clinical diagnoses.

Employee's Signature _____
Date

Do you wish to talk to an Employee Health Care Provider concerning this questionnaire?
Yes ____ No ____

*******For Medical Provider Use Only*******

Medical Evaluation for Respirator Approval

Physician' Comments: _____

___ Exam Required/Not Required ___ Phone Contact Required ___ Limited Use / Restrictions

Date: _____ Reviewing Physician's Name: _____

Signature