Michigan State University
Occupational Health
463 East Circle Drive
East Lansing, MI 48824-1037
Phone (517) 353-9137

INTERIM MEDICAL QUESTIONNAIRE FOR INDIVIDUALS WHO WEAR A RESPIRATOR

INSTRUCTIONS: Please answer all questions honestly and completely. Questions are for record keeping purposes and to check for heart or lung disease that may place you at risk of becoming ill when you wear a respirator. Information will be kept confidential and will be reviewed by professional medical personnel only. If you wish to talk to the Health Care Professional who will be reviewing this questionnaire, please call MSU Occupational Health at 353-9137.

Name: _____ Last _____ First _____ Middle	
Address: _____ Street _____ City _____ State _____ Zip	
Home Phone: ( )	
ZPID or APID:	Date of Birth:
Department:	Job Title:
Phone number we can reach you at work:	Supervisor:
Were you ever an MSU Student? Yes ☐ No ☐ If Yes, Student #:_____	
Height: (without shoes) _____	
Weight: (without shoes) _____	

Yes No

1. ☐ ☐ Have you ever smoked cigarettes? ("Yes" means more than 20 packs of cigarettes or 12 oz. of tobacco in your life)

IF "YES," ANSWER QUESTIONS 1a-4e. IF "NO," SKIP TO QUESTION 2.

Yes No

☐ ☐ 1a. Do you smoke now?

1b. How old were you when you started smoking regularly? _____

1c. If you stopped, how old were you when you stopped? _____

1d. On the average, how many packs per day have you smoked for the length of time you smoked? _____

1e. How many packs per day do you smoke now? _____

Yes No

2. ☐ ☐ Have you ever had a back injury?

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

Yes No

☐ ☐ 3a. Weakness in any of your arms, hands, legs, or feet

Yes No

☐ ☐ 3b. Back pain

Yes No

☐ ☐ 3c. Difficulty fully moving your head up or down

Yes No

☐ ☐ 3d. Pain or stiffness when you lean forward or backward at the waist

Yes No

☐ ☐ 3e. Difficulty fully moving your head side to side

Yes No

☐ ☐ 3f. Difficulty fully bending at your knees

Yes No

☐ ☐ 3g. Difficulty squatting to the ground

Yes No

☐ ☐ 3h. Difficulty climbing a flight of stairs or a ladder while carrying more than 25 lbs.

Yes No

☐ ☐ 3i. Any other muscle or skeletal problem that might interfere with using a respirator

IF "YES", PLEASE EXPLAIN:

_____

Yes No

4. ☐ ☐ Have you worn a respirator since completing your last respirator questionnaire?
IF "YES," ANSWER QUESTIONS 4a-4m.
IF "NO," SKIP TO QUESTION 5.

4a. How often do wear a respirator? (for example: 3 times per week, 10 times per month)
_____ per week _____ per month _____ per year

4b. How long do you typically wear your respirator without taking it off? (for example: 15 min., .5 hours, 1 hour, 4 hours)

_____

4c. What duties do you perform while using the respirator? (for example: painting, applying pesticides, cleaning, asbestos removal, etc…)

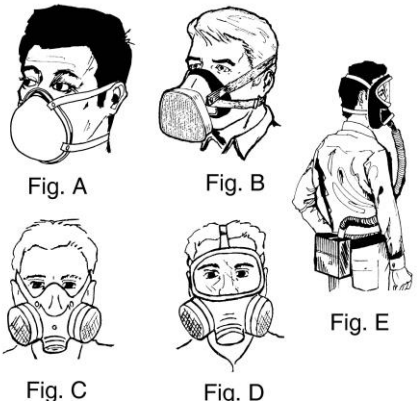
_____

4d. Briefly describe your working environment while wearing your respirator. (For example: research lab, farm area, steam tunnel, penthouse, etc…)

_____

4e. What type of respirator do you wear? (check **all** that apply)

- ☐ Disposable paper dust mask with 1 strap
- ☐ Disposable paper dust mask with 2 straps (Fig. A)
- ☐ Disposable organic vapor mask (Fig. B)
- ☐ Disposable organic vapor/acid gas mask (Fig. B)
- ☐ Reusable half-face mask (Fig. C.)
- ☐ Reusable full-face mask (Fig. D)
- ☐ Powered air purifying respirator (Fig. E)
- ☐ Full-face respirator with an air-line
- ☐ Self contained breathing apparatus (SCBA)
- ☐ Air-line w/ total body suit
- ☐ Other (please specify) _____



4f. Indicate, with a check, whether your usual workload level while you are wearing a respirator is resting, light, moderate, or heavy. Also, indicate with a check, whether your maximum workload level while you are wearing a respirator is resting, light, moderate, or heavy.

Usual	Max.	
☐	☐	**Resting**
☐	☐	**Light** (examples include)—sitting at ease, light hand work, hand and arm work (small bench tools, inspecting, assembly, or sorting of light materials), are and leg work. Standing: drill press (small parts), milling machine (small parts), machining with light power tools.
☐	☐	**Moderate** (examples include)—hand and arm work (nailing, filing), arm and leg work (off road operation of trucks or construction equipment), arm and trunk work (air hammer operation, tractor assembly, plastering, intermittent handling of moderately heavy materials, weeding, hoeing, pushing or pulling light weight cars or wheelbarrows).
☐	☐	**Heavy** (examples include)—heavy arm and trunk work, transferring heavy materials, shoveling, sledge hammer work, sawing, hand mowing, digging, axe work, climbing stairs or ramps, jogging, running, pushing or pulling heavily loaded carts or wheelbarrows, chipping castings, concrete block laying.

Have you ever had any of the following problems when you wore a respirator?

	Yes	No		
	☐	☐	4g.	Eye irritation?
	☐	☐	4h.	Skin allergies or rashes?
	☐	☐	4i.	Anxiety?
	☐	☐	4j.	Persistent general weakness or fatigue?
	☐	☐	4k.	Any other problems that interfere with your use of a respirator? If yes, what?
	☐	☐	4l.	Describe any other difficulties that you had using the respirator?
	☐	☐	4m.	Were you unable to use the respirator because of these difficulties?
5.	☐	☐		Do you have a fear of tight or enclosed places (claustrophobia)?
6.	☐	☐		Do you have a sensation of smothering?
7.	☐	☐		Do you have a ruptured ear drum?
8.	☐	☐		Do you wear contact lenses?

Yes No

9. ☐ ☐ Do you wear glasses?

Yes No

10. ☐ ☐ Have you ever had to have medical treatment for heat exhaustion or heat stroke?

Yes No

11. ☐ ☐ Have you had a breathing test since completing your first respirator questionnaire?
IF "YES", WHAT WERE THE RESULTS?

Normal _____ Abnormal _____ Don't Know _____

Yes No

12. ☐ ☐ Have you had an electrocardiogram since completing your last respirator questionnaire?
IF "YES", WHAT WERE THE RESULTS?

Normal _____ Abnormal _____ Don't Know _____

Yes No

13. ☐ ☐ Do you consider yourself to be in good health?
IF "NO", STATE REASONS:

Yes No

14. ☐ ☐ Do you have any defect of vision (other than corrective lenses)?
IF "YES", STATE THE NATURE OF THE DEFECT:

Yes No

15. ☐ ☐ Do you have any defect of hearing?
IF "YES", STATE THE NATURE OF THE DEFECT:

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

Yes No

☐ ☐ 16a. Epilepsy (or fits, seizures, convulsions)?

Yes No

☐ ☐ 16b. Rheumatic Fever?

Yes No

☐ ☐ 16c. Kidney Disease?

Yes No

☐ ☐ 16d. Bladder Disease?

Yes No

☐ ☐ 16e. Diabetes?
IF "YES," Check treatment(s): ☐ **DIET** ☐ **PILLS** ☐ **INSULIN**

Yes No

☐ ☐ 16f. Allergic reactions that interfere with your breathing?

Yes No

☐ ☐ 16g. Jaundice?

Yes No

☐ ☐ 16h. Trouble smelling odors?

17. Have you ever had any of the following lung conditions?

Yes No

☐ ☐ 17a. Chronic bronchitis

Yes No

☐ ☐ 17b. Pneumonia

Yes No

☐ ☐ 17c. Tuberculosis

Yes ☐ No ☐ 17d. Silicosis

Yes ☐ No ☐ 17e. Pneumothorax (ruptured or collapsed lung)

Yes ☐ No ☐ 17f. Lung cancer

Yes ☐ No ☐ 17g. Emphysema

Yes ☐ No ☐ 17h. Asthma

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

Yes ☐ No ☐ 18a. Shortness of breath that interferes with your job

Yes ☐ No ☐ 18b. Coughing that produces phlegm (thick sputum)

Yes ☐ No ☐ 18c. Coughing that wakes you early in the morning

Yes ☐ No ☐ 18d. Coughing that occurs mostly when you are lying down

Yes ☐ No ☐ 18e. Coughing up blood in the last month

Yes ☐ No ☐ 18f. Wheezing that interferes with your job

Yes ☐ No ☐ 18g. Chest pain when you breathe deeply

Yes ☐ No ☐ 18h. Any other symptoms that you think may be related to lung problems

19. Yes ☐ No ☐ Since completing your last respirator questionnaire have you had any other chest illness?
IF "YES", PLEASE SPECIFY:

_____

20. Yes ☐ No ☐ Since completing your last respirator questionnaire have you had any surgery on your chest?
IF "YES", PLEASE SPECIFY:

_____

21. Yes ☐ No ☐ Since completing your last respirator questionnaire have you had any chest injuries?

IF "YES", PLEASE SPECIFY:

_____

22. Since completing your last respirator have you had any of the following cardiovascular or heart problems?

Yes ☐ No ☐ 22a. Stroke?

Yes ☐ No ☐ 22b. Angina? (heart pain)

Yes ☐ No ☐ 22c. Heart failure?

Yes ☐ No ☐ 22d. Swelling in your legs or feet (not caused by walking)?

Yes ☐ No ☐ 22e. Heart arrhythmia (heart beating irregularly)?

23. Yes ☐ No ☐ Since completing your last respirator questionnaire has a doctor told you that you had a heart attack?

Yes No

24. ☐ ☐ Since completing your last respirator questionnaire has a doctor told you that you had any other kind of heart trouble?
IF "YES," PLEASE SPECIFY:

_____

25. Yes No Do you have irregular or skipped heartbeats?
☐ ☐

26. What was your most recent blood pressure? ____/____
You must provide a blood pressure reading done within the past year. If you have not had a blood pressure reading in the last year, have a blood pressure taken and record the result on the questionnaire before sending the questionnaire to the Occupational Health Clinic. You may also call the Occupational Health Clinic (353-9137) to schedule a time to have your blood pressure taken and you may return the questionnaire at that time.

Yes No

27. ☐ ☐ Has a doctor ever told you that you had high blood pressure?

Yes No

28. ☐ ☐ Have you had any treatment for high blood pressure (hypertension) in the past ten years?
IF "YES," PLEASE LIST WHAT MEDICATION(s) YOU TAKE FOR YOUR HIGH BLOOD PRESSURE:

_____

Yes No

29. ☐ ☐ Do you ever have wheezy or whistling sounds in your chest?

IF "YES", ANSWER QUESTIONS 29A-29C. IF "NO", SKIP TO 30.

Yes No
☐ ☐ 29a. When you have a cold

Yes No
☐ ☐ 29b. Occasionally, apart from a cold

Yes No
☐ ☐ 29c. Most days or nights

IF YOU ANSWERED "YES" TO QUESTIONS A, B, OR C, THEN ANSWER QUESTION 29D.

Yes No
☐ ☐ 29d. How many years has this been present? _____

Yes No

30. ☐ ☐ Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?

Yes No

31. ☐ ☐ Do you have to walk slower than other people your age do on the level because of breathlessness?

Yes No

32. ☐ ☐ Do you ever have to stop for breath when walking at your own pace on the level?

Yes No

33. ☐ ☐ Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level?

34. Yes No Are you too breathless to leave the house or too breathless when you get dressed or climb the stairs?
☐ ☐

35. When was your last general medical examination? _____

36. List all medications you take on a regular basis (include those you can buy without a prescription). If you don't know the name, list what the pill is for (i.e., "heart pill" or "water pill"). Use back if more room is needed.

_____ for _____ _____ for _____
_____ for _____ _____ for _____
_____ for _____ _____ for _____

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

☐ ☐ 37a. Pain or tightness in your chest that interferes with your job
☐ ☐ 37b. Heartburn or indigestion that is not related to eating
☐ ☐ 37c. Any other symptoms that you think may be related to heart or circulation problems.
IF "YES," PLEASE SPECIFY:

Within the past three months:

Yes No
38. ☐ ☐ Have you had any pain or discomfort in your chest?

Yes No
39. ☐ ☐ Have you ever had any pressure or heaviness in your chest?
IF "YES" TO EITHER QUESTIONS 38 OR 39, ANSWER THE FOLLOWING QUESTIONS.
IF "NO" TO QUESTIONS 38 AND 39, SKIP TO QUESTION 46.

Yes No
40. ☐ ☐ Do you get pain, discomfort, pressure, or heaviness when you walk uphill or hurry?
☐ I never hurry or walk uphill

Yes No
41. ☐ ☐ Do you get pain, discomfort, pressure, or heaviness when you walk at an ordinary pace on level ground?

42. What do you do if you get pain, discomfort, pressure, or heaviness while you are walking?
☐ Stop or slow down
☐ Take nitroglycerine
☐ Keep going, without slowing down

43. If you stand still or sit down, what happens to this pain or discomfort?
☐ Not relieved ☐ Relieved

Yes No
44. ☐ ☐ Did you see a doctor because of this pain or discomfort?
IF "YES," WHAT DID HE/SHE SAY IT WAS?

45. If disabled from walking by any condition other than heart or lung disease, describe the nature of the condition(s):

Yes No
46. ☐ ☐ Would you like to talk to the health care professional that will review this questionnaire about your answers to this questionnaire?

You are done! Please email, fax or mail this completed questionnaire: email: occhealth@msu.edu , Fax: (517) 355-0332. or mail to: MSU Occupational Health, 463 East Circle Drive, Room 123 Olin Health Center, East Lansing, MI 48824.