Samaritan Occupational Medicine
2930 NE West Devils Lake Rd #3
Lincoln City, OR 97367

541-557-6427

Newport Office
775 9th St. SW Suite E
Newport, OR 97365
541-574-4675

Samaritan Occupational Medicine

Industrial Audiology Report for: _____ Company Name _____ Date

Name	Date of Birth	Social Security No.	Sex M or F

Occupational History (Beginning with most recent employer)

	Employer	Duties	Length of Service	Noise Exposure	Ear Protectors
1				Yes No	Yes No
2				Yes No	Yes No

Military Service Y or N	Time Served	Branch ❑ Army ❑ Navy ❑ Marines ❑ Air Force ❑ Other	Exposure to gunfire? Y or N
Date Last Worked		Worker's Evaluation of Hearing Status: ❑ Good ❑ Fair ❑ Poor	Exposure to aircraft noise? Y or N

Check if you have had any of the following:

❑ Allergy ❑ Dizziness ❑ Earaches ❑ Frequent Coughs ❑ Influenza ❑ Measles ❑ Mumps
❑ Serious Medical Ailments ❑ Ear Surgery: Type of Operation _____
❑ Industrial Injuries or Disease _____ ❑ Head Injuries ❑ Hearing Impairment in Family
❑ Ringing Ears ❑ Running Ears ❑ Scarlet Fever ❑ Whooping Cough ❑ Other

Do you have hobbies or other jobs that expose you to noise? Y or N Describe: _____
Have you been exposed to noise in the last 14 hours, which you would have to wear hearing protection? Y or N
If yes, were you wearing ear protection? Y or N
Hours since last exposure _____
Have you had a previous hearing test? Y or N Date & Company _____

*Type 1—Baseline 2—Annual 3—Follow-Up

May attach printout or fill out the following:

Date & Time	Type*	Audiometer & SN	Cal Date & STD	Tester (First & Last Name)	Right Ear							Left Ear						
					500	1000	2000	3000	4000	6000	8000	500	1000	2000	3000	4000	6000	8000

Comments:

Hearing Conservation Safety Video Reviewed:
(Only when requested by employer)

Patient Signature _____ Date _____

Technician's Signature & Certification # _____ Date _____

INFORMATION / INFORMED CONSENT
HEPATITIS B VACCINE

THE DISEASE

Hepatitis B is a viral infection caused by Hepatitis B Virus (HBV). Most people with HBV recover completely, but approximately 5-10% becomes a chronic carrier. In the group of chronic carriers, many have no symptoms and appear well, yet can transmit the virus to others. Others may develop a variety of symptoms and liver problems from mild to severe (chronic persistent hepatitis, chronic active hepatitis, cirrhosis and liver failure.) There is also an association between HBV and liver cancer.

Health care workers are at high risk of acquiring HBV due to exposure to infected blood, blood products or body fluids via needle stick, cuts, abrasions, and splashes.

THE VACCINE

Engerix B is a non-infectious Recombinant DNA Hepatitis B Vaccine. It is prepared in yeast cells and contains no live virus. Clinical studies have shown that after three doses, 96% of healthy adults have developed the antibody to Hepatitis B.

POSSIBLE VACCINE SIDE EFFECTS

Engerix B is generally well tolerated. As with any vaccine, however, it is possible that expanded commercial use of the vaccine could reveal rare adverse reactions not observed in clinical studies. The most frequently reported adverse reactions are injection-site soreness, fatigue, induration, erythema, swelling, fever, headache and dizziness.

SPECIAL PRECAUTIONS

No serious adverse reactions have been reported. However, as with any vaccine or drug, the possibility of some severe or potentially fatal reaction must be considered.

Hepatitis B Vaccine will NOT be given to the following:

- People who are allergic to thimersol, a mercury based preservative.
- People with previous HBV infection.
- People with active infection.
- Hypersensitivity to yeast or any other component of the vaccine.
- Pregnant women unless authorized by their physician and given written consent.

CONSENT TO ADMINISTRATION OF HEPATITIS B VACCINE

I have read the information about Hepatitis B and Hepatitis B Vaccine (Energix B). I have had the opportunity to ask questions about the benefits and risks of Hepatitis B Vaccination. I understand that, as with all medical treatment, there is no guarantee that I will not experience an adverse side effect to the vaccine or that I will become immune.

. **Hep B Vis sheet offered – Date: _____Initial: _____Publication Date:_____**

#1 _____

Signature Date Mfg & Lot # Inj Site Exp Date Given By

. **Hep B Vis sheet offered – Date: _____Initial: _____Publication Date:_____**

#2 _____

Signature (2^{nd} Thirty days after initial) Date Mfg & Lot # inj Site Exp Date Given By

. **Hep B Vis sheet offered – Date: _____Initial: _____Publication Date:_____**

#3 _____

Signature (3^{rd} Six months after the initial injection) Date Mfg & Lot # Inj Site Exp Date Given By

_____

Titer (Titer 4 weeks after 3^{rd} injection) Date Drawn By

PRINT NAME: _____

Social Security #_____ Company _____

Samaritan Occupational Medicine

Cascade Medical Associates
in conjunction with

Patient Name:_____
Company Name:_____
Date:_____

OCCUPATIONAL HISTORY

List dates, employer and occupations you have worked in last *five years*. Please print.

DATE From	To	COMPANY	OCCUPATION

CHECK IF YOU HAVE WORKED IN THE FOLLOWING OCCUPATIONS:

☐ Asbestos ☐ Foundry ☐ Grinding ☐ "Sand Blasting " ☐ Silica ☐ Spray/Brush Painting

☐ Plating ☐ Glass Mfg. ☐ Mining (kind_____) ☐ Stone Cutting

CHECK IF YOU HAVE EVER BEEN EXPOSED TO ANY OF THE FOLLOWING (WHETHER AT HOME, WORK, OR IN ANY SETTING):

☐ Substances which caused you breathing difficulties ☐ Substances which irritated your skin or eyes ☐Sprays/powders for insects or plants

☐ Dusty conditions, such as sandblasting, binding or drilling of rock, coal, silica, or asbestos products ☐ Prolonged loud noises

HAVE YOU EVER HAD AN ADVERSE (BAD) REACTION TO:

☐ High environmental temperatures ☐ Low environmental temperatures ☐ High altitudes or heights

Personal Ocular History

1. Lazy eye: ☐ Yes ☐ No **2.** Turned eye: ☐ YES ☐ NO **3.** Dry eyes/Burning eyes: ☐ YES ☐ NO

4. Eye infections: ☐ YES ☐ NO **5.** ☐ YES ☐ NO **6.** Double Vision: ☐ YES ☐ NO

7. Glaucoma: ☐ YES ☐ NO **8.** Cataracts: ☐ YES ☐ NO **9.** Macular degeneration: ☐ YES ☐ NO

8. Keratoconus: ☐ YES ☐ NO **9.** Retinal detachment ☐ YES ☐ NO **1 0:** Flashes/Floaters: ☐ YES ☐ NO

11. Color Deficiency: ☐ YES ☐ NO

Other_____

1. Have you ever had an eye injury? ☐ YES ☐ NO

Type_____Date_____

2. Eye Surgeries? ☐ YES ☐ NO

Type_____Date_____

3. Do you currently wear glasses? ☐ YES ☐ NO

4. Contact Lenses? ☐ YES ☐ NO

5. What type? Soft_____Hard_____

Samaritan Occupational Medicine

Cascade Medical Associates
In conjunction with

Patient Name:_____
Company Name:_____
Date:_____

MEDICAL PROFILE

Check (✓) any of the following conditions that apply or have ever applied to you:

1 ☐ Alcoholism
2 ☐ Drug Abuse
3 ☐ Asthma
4 ☐ Allergies
5 ☐ Hay Fever
6 ☐ Shortness of Breath
7 ☐ Coughing or Frequent Colds
8 ☐ Coughing Blood
9 ☐ Nose or Sinus Trouble
10☐ Pneumonia or Pleurisy
11☐ Tuberculosis or Lung Trouble
12☐ Hearing Difficulties
13☐ Bowel Habit Change
14☐ Liver Disease or Jaundice
15☐ Stomach Trouble, Nausea or Vomiting
16☐ Ulcers
17☐ Vomiting Blood
18☐ Hemorrhoids or Rectal Trouble
19☐ Back or Spinal Injury
20☐ Back Trouble or Sore Back
21☐ Dislocated Vertebra
22☐ Neck Strain or Stiffness
23☐ Broken Bones or Bone Disease
24☐ Elbow Injury or Trouble
25☐ Foot Trouble, Deformed Foot
26☐ Joint Problems
27☐ Knee Injury
28☐ Rheumatism or Arthritis
29☐ Shoulder, Arm, or Hand Pain
30☐ Trick or Locked Knee
31☐ Diabetes
32☐ Gall Bladder Trouble
33☐ Thyroid Trouble
34☐ Gout
35☐ Heart Trouble -- Pain/Attack
36☐ Chest Pain
37☐ High Blood Pressure
38☐ Swelling of Ankles or Feet
39☐ Varicose Veins
40☐ Polio or Meningitis
41☐ Stroke
42☐ Epilepsy
43☐Headache/Migraine, Frequent/Severe
44☐ Head Injury -- Any Type
45☐ Fainting Spells or Dizziness
46☐ Nervous Trouble or Breakdown
47☐ Numbness/Weakness/Tiredness
48☐ Anemia or other Blood Diseases
49☐ Cancer, Cyst, Growth or Tumor
50☐ Boils or Skin Disease
51☐ Rash or Hives
52☐ Hernia

Answer each of the following:

1. Have you had or have now, illnesses or injuries other than those listed above? ☐ Yes ☐ No
2. Have you ever seen an orthopedist? (bone or joint doctor) ☐ Yes ☐ No
3. Have you ever had, or been advised, to have surgery? ☐ Yes ☐ No
4. Have you any physical complaint, impairment or disability at present? ☐ Yes ☐ No
5. Are you taking any medicines, supplements, or drugs now? ☐ Yes ☐ No
6. Are you under the care of a doctor, healer, or other practitioner at the present time? ☐ Yes ☐ No
7. Is there any reasons you would be ***UNWILLING*** or ***UNABLE*** to wear required safety protection such as safety shoes, hard hat, safety glasses, ear plugs, ear muffs, gloves and other required safety gear? ☐ Yes ☐ No
8. Were you medically discharged from the military? ☐ Yes ☐ No
9. Do you have a service connected disability? ☐ Yes ☐ No
10. Do you have any form of permanent disability as a result of an on the job injury? ☐ Yes ☐ No
11. Have you ever had a work related injury or illness? ☐ Yes ☐ No
12. In the past five years, how many weeks have you lost from work related injury?_____
13. When was your last tetanus shot?_____
14. Do you have any drug allergies? If so, please list:_____

List all significant medical problems and hospitalizations, including operations or injuries such as any injury to muscles, joints, ligaments, back or neck in any work, sports, motor vehicle accident or other incident. List most recent first.

Date	Medical Problems/Operations/Injuries	Causing Problem Now Yes	No

I understand that this physical examination is being done to help my employer place me in a position for which I am medically qualified and that this examination is not intended to replace my routine, annual physical examination with my primary care Doctor. I hereby certify that, to the best of my knowledge, the foregoing answers are complete and correct.

Signature of Worker_____Date_____

Samaritan Occupational Medicine

Cascade Medical Associates
In conjunction with

Patient Name:_____
Company Name:_____
Date:_____

VISION SCREEN	R	L	Both
DISTANT VISION			
☐ UNCORRECTED	20/	20/	20/
☐ CORRECTED	20/	20/	20/

HORIZONTAL FIELD OF VISION: R_____° L_____°

COLOR VISION: ☐ OK ☐ Referred to Physician

AMSLER GRID: Normal ☐ YES ☐ NO.

Attach copy of Grid. Mark any abnormalities.

PHYSICIAN SIGNATURE:_____DATE_____

Samaritan
Occupational Medicine
Building healthier communities together

Cascade Medical Associates

Newport Location
775 SW 9th St, Ste E -- Newport, OR 97365
Ph: 541-574-4675 - Fx: 541-574-4965

TB SCREENING

Employer:_____

Name:_____ Date of Birth:_____

Address:_____ Phone #:_____

_____ SS#:_____

Intradermal PPD for Screening

Yes	No	
☐	☐	Under age 15?
☐	☐	Previous positive reaction to PPD or tine test?
☐	☐	Previous BCG vaccine?
☐	☐	Immunocompromised or undergoing immunotherpay?

All answers must be no in order to administer a PPD per protocol. If any YES answers, the provider must evaluate the patient prior to this screening procedure.

SCREENING RECORD

TB Vis sheet offered – Date: _____ **Initials:** _____ **Publication Date:**_____

PPD Manufacturer/Lot #_____ Expiration Date:_____

Location of intradermal injection:_____ **Administered by:**_____

Date Administered:_____ Reading Due on:_____

Date of Reading:_____ Negative (mm Induration):_____

Reader's Signature:_____ ●Positive (mm Induration):_____

●**Contact Employer:** _____ Date_____

● ☐ Refer to Occupational Medicine for Medical Review ☐ Refer to Primary Care Physician for Medical Review

I understand and authorize Samaritan Occupational Medicine to release results of the services provided on:
_____ to _____.
(Date) (Name of Company)
I further understand that if I give my consent to submit to such medical services, results and other relevant medical information will be released to persons authorized by the clinic for appropriate review and response.
I agree to allow release of such information.

_____

Signature Phone Number Date

Samaritan Pacific Communities Hospital
Rehabilitation Service
Post Offer Screening

Fire Fighter

Name: _____

Age: _____ Male ☐ Female ☐

Date: _____

Any current restrictions by a provider which limits your physical functions?	Yes ☐	No ☐
Any previous injuries that would limit your physical functions?	Yes ☐	No ☐
Blood Pressure _____ Must be < 160/100		
Resting Heart Rate _____ Must be < 110 85% age adjust HR _____		
Range of Motion Screen all motions With in Functional Limits	Yes ☐	No ☐
Balance Screen: 30 seconds each foot, tandem walk on air foam cushion x 20 feet forward/backward	Yes ☐	No ☐
Manual Muscle Strength Screening Muscle Grade 5/5 UE & LE	Yes ☐	No ☐

Comments: _____

FUNCTIONAL JOB TASK	REQUIREMENT	RESULT	DEMANDS	
1. Hand Grip	R _____ _____ _____ L _____ _____ _____			
2. Squat	20 x		Met ☐	Not Met ☐
3. Walk 6 minute Test	Age <40 600 yds 40-49 550 yds 50-59 492 yds 60-69 435 yds		Met ☐	Not Met ☐
4. Static push / pull	Push _____ Pull _____			
5. 1 handed carry	50 lbs. x 100 feet		Met ☐	Not Met ☐
6. Crawling	30 feet		Met ☐	Not Met ☐
7. Overhead work	2 lbs. on arms 2 minutes		Met ☐	Not Met ☐
8. 2 Handed Carry	50 lbs. x 100 feet		Met ☐	Not Met ☐
9. Forward bending standing	5 minutes (using hand tools)		Met ☐	Not Met ☐
10. Pulling (simulated individual 200 lbs.)	Weighted sled 100 feet 200 lbs.		Met ☐	Not Met ☐
11. Lifting	50 lbs. floor to waist (start 20, 30, 50 lbs.)		Met ☐	Not Met ☐
12. Lifting	50 lbs. waist to crown level (start 20, 30, 50 lbs.)		Met ☐	Not Met ☐
13. Stair climbing	60 steps up / down carrying 40 lbs.		Met ☐	Not Met ☐

COMMENTS / CONCERNS: _____

Summary: All Functional Job Tasks Met ☐ Not Met ☐

_____
Therapist

Referral to PT/OT for Pre-Work Screen & Physician Review

Physician: _____

Samaritan Occupational Medicine

Building healthier communities, together

Cascade Medical Associates

Dear Employee,

Your employer is required by OR-OSHA to have any employee that wears a respirator fill out the enclosed questionnaire. Samaritan Occupational Medicine is the medical group that reviews the questionnaire to determine if further medical evaluation is necessary before you wear a respirator.

The following is a list of things you need to do:

- Fill out OSHA Respirator Questionnaire (according to employer instructions)
- **If you (employee) answer yes to any question, give a written explanation in the margin or on a separate sheet and fill out the Supplemental Respirator Questionnaire.**
- Sign the release of information form (by signing this form, employee agrees that a copy of the "Certification for Respirator Use" form will be returned to employer).
- Fax **OSHA Respirator Questionnaire, Supplemental Respirator Questionnaire** (if completed) and **Release of Information Form** to Samaritan Occupational Medicine. Attention: Provider at (541) 574-4865 Newport

Be sure to include your **daytime phone number** on the questionnaire, as the provider may need to call and ask for additional information.

If you have any questions or need assistance, please call

Lois Smith 541-996-2233
North Lincoln Fire & Rescue
PO Box 200
Lincoln City, OR 97367

Sincerely,

Occupational Medicine Staff

SAMARITAN OCCUPATIONAL MEDICINE

Limited Authorization for Release of Information

To Be Filled Out by the Patient

I authorize Samaritan Occupational Medicine to release a certificate of the results of this OSHA Respirator Medical Evaluation Questionnaire to: N. Lincoln Fire & Rescue (NLFR) (Employer Name)

Print Name | Social Security # | Date of Birth

Signature | Date

Return this form with OSHA Respirator Medical Questionnaire to:

Samaritan Occupational Medicine
775 SW 9th St, Suite E
Newport, OR 97365
Fax (541) 574-4965
Phone (541) 574-4675

Bring to appointment.

Samaritan Occupational Medicine
OSHA Respirator Medical Evaluation Questionnaire
(Ref: appendix C to 29 CFR 1910.134)

EMPLOYEE (VOLUNTEER): Can you read? YES NO
Can you read English? YES NO

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.

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).

Company_____ Job Title_____

Name _____ Date _____

Date of Birth:_____

Age (to nearest year): _____ Sex : ☐Male ☐Female

Height: _____ft._____in Weight: _____lbs.

Employee phone number (include area code) __(_____)_____

Employer phone number (include area code): __(_____) _____

The best time to reach you:_____

1. Has your employer told you how to contact the health care professional who will review this questionnaire? YES NO
2. Check the type of respirator you will use (you can check more than one category):
   ☐ N,R, or P disposable respirator (filter-mask, non-cartridge type only)
   ☐ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air self-contained breathing apparatus)

3. Have you worn a respirator? ☐ YES ☐ NO If "yes" what type(s): _____
   _____

Part A.
Section 2 (Mandatory) Questions 1 through 9 below must be answered by every employee (Volunteer) who has been selected to use any type of respirator (please mark "yes" or "no"). **For any "Yes" responses, please provide a brief explanation including whether it is a past or current problem, and any pertinent details.**

1. **Do you currently smoke tobacco**, or have you smoked tobacco in the last month? YES NO
   If yes, how many packs?_____ How many years?_____

2. **Have <u>you ever had</u> any of the following conditions?**
   YES NO 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 spaces)
   YES NO e. Trouble smelling odors

3. **<u>Have you had any</u> of the following pulmonary or lung problems?**
   YES NO 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
   YES NO i. Lung Cancer
   YES NO j. Broken Ribs
   YES NO k. Any chest injuries or surgeries
   YES NO l. Any other lung problems that you've been told about

4. **Do you currently have any of the following symptoms of pulmonary or lung illness?**
   YES NO 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

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

YES NO 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 of

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

YES NO 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

7. **Do you currently take medication for any of the following problems? Please list them if possible.**

YES NO a. Breathing or lung problems _____
YES NO b. Heart trouble _____
YES NO c. Blood pressure _____
YES NO d. Seizures (fits) _____

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 box and go to question 9.) ☐

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?

9. **Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?**

YES NO

Questions 10 to 15 below 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.

10. **Have you ever lost vision in either eye (temporarily or permanently)?**

YES NO

11. **Do you currently have any of the following vision problems?**
YES NO a. Wear contact lenses
YES NO b. Wear glasses
YES NO c. Color blind
YES NO d. Any other eye or vision problem

12. **Have you ever had an injury to your ears, including a broken ear drum?**
YES NO

13. **Do you currently have any of the following hearing problems?**
YES NO a. Difficulty in hearing
YES NO b. Wear a hearing aid
YES NO c. Any other hearing or ear problem

14. **Have you ever had a back injury?**
YES NO

15. **Do you currently have any of the following musculoskeletal problems?**
YES NO 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. Difficulties 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 25lbs
YES NO j. Any other muscle or skeletal problem that interferes with using a respirator

Part B.

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 a feeling of dizziness, shortness of breath, pounding in your chest or other symptoms when you're working under these conditions?
YES NO

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., 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:

YES NO a. Asbestos
YES NO b. Silica (e.g., in sandblasting)
YES NO c. Tungsten/cobalt (e.g., grinding or welding this material)
YES NO d. Beryllium
YES NO e. Aluminum
YES NO f. Coal (for example, mining)
YES NO g. Iron
YES NO h. Tin
YES NO i. Dusty environments
YES NO j. Any other hazardous exposures

If "YES" describe these exposures:

_____

_____

4. List any second jobs or side business 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

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier n 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)?

YES NO a. HEPA Filters
YES NO b. Canisters (for example, gas masks)
YES NO c. Cartridges

11. How often are you expected to use the respirator(s)? (Mark yes or no for all that apply to you.)

YES NO 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

12. During the period you are using the respirator(s), is your work effort:
    a. Light (less than 200 kcal per hour) YES NO

Examples of 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.

*If "yes", how long does this period last during the average shift: _____hrs. _____mins.

b. Moderate (200 to 350 kcal per hour) YES NO

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 35lbs.) 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.

*If "yes", how long does this period last during the average shift: _____hrs. _____mins.

c. Heavy (above 350 kcal per hour) YES NO

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 a 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs).

*If "yes", how long does this period last during the average shift: _____hrs. _____mins.

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator?
    YES NO

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

    _____

    _____

14. Will you be working under hot conditions (temp. exceeding 77° F)?
    YES NO

15. Will you be working under humid conditions?
    YES NO

16. Describe the work you'll be doing while you're using your respirator(s).

    _____

    _____

17. Describe any special or hazardous conditions you might encounter when you're 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'll be exposed to when you're using your respirator(s).

Name of the toxic substance: _____
Estimated maximum exposure level per shift: _____
Duration of exposure per shift: _____
Name of **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'll be exposed to while using your respirator:
_____
_____

18. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):_____

Supplemental Respirator Questionnaire

If you answered yes to any question 1-8 in Part A Section 2 of the OSHA Respirator Medical Evaluation Questionnaire please complete the following additional questions.

1. Check if any of the following apply to you:
   _____Wear dentures
   _____Missing any front teeth (upper or lower)
   _____Wear contact lenses
   _____Beard
   _____Mustache

2. Do you smoke?
   _____Yes (If you regularly smoke cigarettes, cigars or a pipe or have quit smoking within the last month).
   _____No (If you have never smoked as much as one cigarette per day, or ___oz. of tobacco a month, for as long as one year).

3. What have you smoked and for how many years? Skip this question if you answered "no" to question #2.

	# of years	Packs per day
Pipe	_____ (# of years)	_____Less than ½ pack
Cigars	_____(# of years)	_____½ to 1 pack
Cigarettes	_____(# of years)	_____1 pack to 1 ½ pack
		_____1 ½ packs or more

1. If you are an ex-smoker, how long since you stopped smoking?
   _____0-1 year
   _____1-4 years
   _____5-9 years
   _____10+ years

4. Have you had past problems with respirator use in any type of work situation?
   _____yes _____no

6. Do you have any psychological problems that might interfere with the use of a respirator? (Example: panic attacks, claustrophobia, anxiety or fear of being in an enclosed area)
   _____yes _____no

7. List present medications that you regularly use:

Medication	Used for what reason?
_____	_____
_____	_____
_____	_____

8. Are you currently under the care of a doctor? _____Yes _____No

If yes, for what condition? _____

Employee Signature_____ Date_____