



Respirator Questionnaire

This questionnaire is used in determining whether or not you have a medical condition that may affect your ability to wear a respirator. In some cases, we may ask for more information. All medical information is considered confidential.

Name: Last First Initial Soc. Sec. No. Job Title Department:

Today's Date: Type of Exam: Initial Periodic

Information provided by Safety & Health Consultant or Supervisor. Name:

Check type of respirator(s) to be used: Airline supplied & SCBA Full-face Half-face Other

Average hours worn per each use: Frequency of use per day, week, month, year:

Check nature of work performed while wearing respirator (see Respiratory Protection Protocol for definition) Light Heavy Mod

List additional protective clothing and equipment to be worn:

Temperature and humidity extremes encountered? Yes No

To the employee: Can you read? 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).

- 1. Your age (to the nearest year):
2. Sex (mark one): Male Female
3. Your height: ft in. Your weight: lbs.
4. Your job title:
5. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the area code): The best time to phone you at this number:
6. Has your employer told you how to contact the health care professional who will review this questionnaire (mark one): Yes No
7. 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-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus)
8. Have you worn a respirator (mark one): Yes No If yes, what type(s):

Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respiratory. Please mark "yes" or "no".

- 1. Yes No Do you currently smoke tobacco, or have you smoked tobacco in the past?
2. Have you ever had any of the following conditions?
Yes No
A. Seizures (fits) B. Diabetes (sugar disease)
C. Trouble smelling odors D. Claustrophobia (fear of closed-in places)
E. Allergic reactions that interfere with your breathing

Part A. Section 2 Continued:

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

- | <u>Yes</u> | <u>No</u> | | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | A. Asbestosis | <input type="checkbox"/> | <input type="checkbox"/> | B. Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | C. Chronic bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | D. Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | E. Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | F. Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | G. Silicosis | <input type="checkbox"/> | <input type="checkbox"/> | H. Pneumothorax (collapsed lung) |
| <input type="checkbox"/> | <input type="checkbox"/> | I. Lung cancer | <input type="checkbox"/> | <input type="checkbox"/> | J. Broken ribs |
| <input type="checkbox"/> | <input type="checkbox"/> | K. Any chest injuries or surgeries | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | L. Any other lung problem that you've been told about. _____ | | | |

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

- | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | A. Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | B. Shortness of breath when walking fast on level ground or walking up a slight hill or incline |
| <input type="checkbox"/> | <input type="checkbox"/> | C. Shortness of breath when walking with other people at an ordinary pace on level ground |
| <input type="checkbox"/> | <input type="checkbox"/> | D. Have to stop for breath when walking at your own pace on level ground |
| <input type="checkbox"/> | <input type="checkbox"/> | E. Shortness of breath when washing or dressing yourself or that interferes with your job |
| <input type="checkbox"/> | <input type="checkbox"/> | F. Coughing that produces phlegm (thick sputum) |
| <input type="checkbox"/> | <input type="checkbox"/> | G. Coughing that wakes you early in the morning |
| <input type="checkbox"/> | <input type="checkbox"/> | H. Coughing that occurs mostly when you are lying down |
| <input type="checkbox"/> | <input type="checkbox"/> | I. Wheezing at work or away from work |
| <input type="checkbox"/> | <input type="checkbox"/> | J. Chest pain when you breathe deeply |
| <input type="checkbox"/> | <input type="checkbox"/> | K. 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?

- | <u>Yes</u> | <u>No</u> | | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | A. Heart attack | <input type="checkbox"/> | <input type="checkbox"/> | B. Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | C. Angina | <input type="checkbox"/> | <input type="checkbox"/> | D. Heart failure |
| <input type="checkbox"/> | <input type="checkbox"/> | E. High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | F. Heart arrhythmia (beating irregularly) |
| <input type="checkbox"/> | <input type="checkbox"/> | G. Swelling in your legs or feet (not caused by walking) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | H. Any other heart problem that you've been told about: _____ | | | |

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

- | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | A. Frequent pain or tightness in your chest |
| <input type="checkbox"/> | <input type="checkbox"/> | B. Pain or tightness in your chest during physical activity or that interferes with your job |
| <input type="checkbox"/> | <input type="checkbox"/> | D. In the past two years, have you noticed your heart skipping or missing a beat |
| <input type="checkbox"/> | <input type="checkbox"/> | E. Heartburn or indigestion that is not related to eating |
| <input type="checkbox"/> | <input type="checkbox"/> | 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? If yes, please list medications.

- | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | A. Breathing or lung problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | B. Heart trouble _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | C. Blood pressure _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 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, mark no space and go to question 9).

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | A. Eye irritation |
| <input type="checkbox"/> | <input type="checkbox"/> | B. Skin allergies or rashes |
| <input type="checkbox"/> | <input type="checkbox"/> | C. Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | D. General weakness or fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 your answers to this questionnaire?

The following questions (10-15) must be answered by every employee who has been selected to use either a full-facepiece 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. Yes No
 Have you ever lost vision in either eye (temporarily or permanently)?

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

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	A. Wear contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	B. Wear glasses
<input type="checkbox"/>	<input type="checkbox"/>	C. Color blind	<input type="checkbox"/>	<input type="checkbox"/>	D. Any other eye or vision problem

12. Have you ever had an injury to your ears, including a broken ear drum?

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

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	A. Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	B. Wear a hearing aid
<input type="checkbox"/>	<input type="checkbox"/>	C. Any other hearing or ear problem			

14. Have you ever had a back injury?

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

<u>Yes</u>	<u>No</u>		
<input type="checkbox"/>	<input type="checkbox"/>	A. Weakness in any of your arms, hands, legs, or feet	
<input type="checkbox"/>	<input type="checkbox"/>	B. Back pain	
<input type="checkbox"/>	<input type="checkbox"/>	C. Difficulty fully moving your arms and legs	
<input type="checkbox"/>	<input type="checkbox"/>	D. Pain or stiffness when you lean forward or backward at the waist	
<input type="checkbox"/>	<input type="checkbox"/>	E. Difficulty fully moving your head up or down or side-to-side	
<input type="checkbox"/>	<input type="checkbox"/>	F. Difficulty bending at your knees or squatting to the ground	
<input type="checkbox"/>	<input type="checkbox"/>	G. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.	
<input type="checkbox"/>	<input type="checkbox"/>	H. Any other muscle or skeletal problem that interferes with using a respirator: _____	

PART B

Section 1. Please answer the following questions by marking the appropriate box or filling in the space.

1. Yes No
 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?
 If yes, name the chemicals: _____

2. Have you ever worked with any of the materials, or under any of the conditions, listed below:

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	A. Asbestos	<input type="checkbox"/>	<input type="checkbox"/>	B. Silica (e.g., in sandblasting)
<input type="checkbox"/>	<input type="checkbox"/>	C. Tin	<input type="checkbox"/>	<input type="checkbox"/>	D. Beryllium
<input type="checkbox"/>	<input type="checkbox"/>	E. Aluminum	<input type="checkbox"/>	<input type="checkbox"/>	F. Coal (for example, mining)
<input type="checkbox"/>	<input type="checkbox"/>	G. Iron	<input type="checkbox"/>	<input type="checkbox"/>	H. Dusty environments
<input type="checkbox"/>	<input type="checkbox"/>	I. Tungsten/cobalt (e.g., grinding or welding this material)			
<input type="checkbox"/>	<input type="checkbox"/>	J. Any other hazardous exposures.			

If yes, describe these exposures: _____

3. List any second jobs or side business you have: _____

4. Yes No
 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)?
 If yes, name the medications: _____

PART B Section 1 Continued

5. How often are you expected to use the respirator(s)? Mark Yes or No for all answers that apply to you.

- | <u>Yes</u> | <u>No</u> | | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | A. Escape only (no rescue) | <input type="checkbox"/> | <input type="checkbox"/> | B. Emergency rescue only |
| <input type="checkbox"/> | <input type="checkbox"/> | C. Less than 5 hours per week | <input type="checkbox"/> | <input type="checkbox"/> | D. Less than 2 hours per day |
| <input type="checkbox"/> | <input type="checkbox"/> | E. 2 to 4 hours per day | <input type="checkbox"/> | <input type="checkbox"/> | F. Over 4 hours per day |

6. During the period you are using the respirator(s), is your work effort:

- | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | A. Light (less than 200 kcal per hour)
If yes, how long does this period last during the average shift: _____ hrs _____ mins.
<i>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.</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | B. Moderate (200 to 350 kcal per hour)
If yes, how long does this period last during the average shift: _____ hrs _____ mins.
<i>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.</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | C. Heavy (above 350 kcal per hour)
If yes, how long does this period last during the average shift: _____ hrs _____ mins.
<i>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.).</i> |

Yes No

7. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator?
If yes, describe this protective clothing and/or equipment: _____
8. Will you be working under hot conditions (temperature exceeding 77° F)?
9. Will you be working under humid conditions?
10. Describe the work you'll be doing while you're using your respirator(s): _____

Patient Signature: _____ Date: _____

Reviewers Signature: _____ Date: _____

As part of an effort to help you optimize your health, this medical appraisal is being offered. The information on this form is to provide background for your health record and to assist the physician with your examination. Please answer this medical history as completely as possible. You will have an opportunity to discuss your answers with the physician at the time of your examination.

All medical information will be handled in the strictest confidence. Management will not be provided with specific medical data and will be advised only of any work restrictions necessary for your health and safety or the health and safety of others. Any release of medical data will be done only with your consent, unless required or permitted by law.

NAME					
PERSONAL HEALTH HISTORY					
When have you last received the following immunizations:		Have you ever been absent from school, work or military service for more than 14 days? (If yes, please describe)			
Tetanus (DPT) _____	Rubella _____				
Mumps _____	Measles _____				
BCG _____	Influenza A _____				
Hepatitis A _____	Hepatitis B _____				
Pneumococcal _____					
TB test _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative		Medicines or pills taken: (list all, even vitamins and aspirin) _____			
PAST MEDICAL HISTORY					
HAVE YOU EVER BEEN TREATED FOR:					
	Yes	No		Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Backache
<input type="checkbox"/>	<input type="checkbox"/>	Blood clot in a vein	<input type="checkbox"/>	<input type="checkbox"/>	Broken bone
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	Ear trouble	<input type="checkbox"/>	<input type="checkbox"/>	Eye trouble
<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones
<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	Kidney trouble	<input type="checkbox"/>	<input type="checkbox"/>	Lung trouble
<input type="checkbox"/>	<input type="checkbox"/>	Nervous exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Sick headaches
<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins		<input type="checkbox"/>	Arthritis
				<input type="checkbox"/>	Back Injury
				<input type="checkbox"/>	Bronchitis
				<input type="checkbox"/>	Chronic indigestion
				<input type="checkbox"/>	Diabetes
				<input type="checkbox"/>	Fainting spells
				<input type="checkbox"/>	Goiter
				<input type="checkbox"/>	Jaundice
				<input type="checkbox"/>	Nervous breakdown
				<input type="checkbox"/>	Pleurisy
				<input type="checkbox"/>	Rupture
				<input type="checkbox"/>	Sinus trouble
				<input type="checkbox"/>	Ulcer
INDICATE IF YOU HAVE EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS. (CHECK IF YES)					
<input type="checkbox"/>	Anemia / Bleeding Disorders / Blood Diseases		<input type="checkbox"/>	Asthma / Emphysema / Bronchitis / Other respiratory problems	
<input type="checkbox"/>	Breathing difficulties or problems / Chronic cough		<input type="checkbox"/>	Loss of consciousness / Seizures / Convulsions	
<input type="checkbox"/>	Hepatitis / Liver Disease / Gallstones		<input type="checkbox"/>	Kidney Disease / Kidney Stones / Kidney problems -	
<input type="checkbox"/>	Sexually Transmitted Diseases		<input type="checkbox"/>	Diabetes / Sugar Disorders	
<input type="checkbox"/>	Neck / Back problems		<input type="checkbox"/>	Knee Problems	
<input type="checkbox"/>	Cancer / Tumor/ Leukemia		<input type="checkbox"/>	Arthritis / Rheumatism / Joint Problems	
<input type="checkbox"/>	Deafness / Hearing Loss / Ear Problems		<input type="checkbox"/>	Color Blindness / Vision Problems	
<input type="checkbox"/>	Any blood transfusions		<input type="checkbox"/>	Any infectious disease	
<input type="checkbox"/>	Any allergies to foods or other		<input type="checkbox"/>	Heart attack / Angina	
<input type="checkbox"/>	High Blood Pressure / Heart Disease / Heart Murmur		<input type="checkbox"/>	Claustrophobia	
<input type="checkbox"/>	Digestive problems / Ulcer / Bowel Disease		<input type="checkbox"/>	Psychiatric / Emotional Problems	
<input type="checkbox"/>	Alcoholism / Drug Addiction		<input type="checkbox"/>	Sinus problems / Hay Fever	
<input type="checkbox"/>	Skin Allergy or Sensitivity		<input type="checkbox"/>	Hospitalization for any reason	
<input type="checkbox"/>	Ever been injured		<input type="checkbox"/>	None of the above	
<input type="checkbox"/>	Other medical problems not listed above, including any work-related medical condition or workers' compensation claim		<input type="checkbox"/>	Allergy to Medications (list) _____	
INDICATE IF YOU HAVE EVER HAD ANY OF THE FOLLOWING OPERATIONS / INJURIES (CHECK IF YES)					
<input type="checkbox"/>	Splenectomy (removal of spleen)		<input type="checkbox"/>	Ulcer / Stomach surgery	
<input type="checkbox"/>	Colon / Rectal / Bowel Surgery		<input type="checkbox"/>	Hysterectomy / Removal of Ovaries	
<input type="checkbox"/>	Hernia Repair		<input type="checkbox"/>	Thyroid Surgery	
<input type="checkbox"/>	Appendectomy		<input type="checkbox"/>	Any broken bones	
<input type="checkbox"/>	Other surgery or injury, including auto accidents and work-related injuries		<input type="checkbox"/>	Neck / Back / Knee Surgery	
			<input type="checkbox"/>	Vasectomy / Tubal Ligation	
			<input type="checkbox"/>	Gallbladder Surgery	
			<input type="checkbox"/>	Any kind of other Operation	
			<input type="checkbox"/>	None of the above	

SOCIAL HISTORY

Marital Status: Single Married Divorced Widowed Do you have children? Yes No Boys Girls

Do you have pets? Cats Dogs Other _____

In which of the following hobbies do you participate?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Hunting/Target Shooting | <input type="checkbox"/> Car Repair | <input type="checkbox"/> Flying | Do you have any hobbies involving adverse exposures?
<input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, explain) |
| <input type="checkbox"/> Art/Ceramics/Jewelry | <input type="checkbox"/> Furniture Refinishing | <input type="checkbox"/> Photographic Development | |
| <input type="checkbox"/> Motorcycle Riding | <input type="checkbox"/> Welding | <input type="checkbox"/> Boat/Car Racing | |
| <input type="checkbox"/> Gardening | <input type="checkbox"/> Loud Music | <input type="checkbox"/> Other | |
| <input type="checkbox"/> Wood/Metalworking | <input type="checkbox"/> Electronics | <input type="checkbox"/> None of the above | |

Cigarette Use

As of one month ago, did you smoke cigarettes?
 Yes No

If yes, what was the average number of cigarettes smoked? _____

Have you ever regularly smoked cigarettes?
 Yes No

If yes, age began? _____

Over the entire time you smoked, what was your average number of cigarettes smoked per day?
 1-10 11-20
 21-40 More than 40

Total number of years you smoked? _____

If you quit smoking, at what age? _____

Have you ever regularly smoked cigars or a pipe? Yes No

Have you ever regularly used snuff or chewing tobacco? Yes No

Have you ever chewed Nicotine gum?
 Yes No

Alcohol Use

Have you ever regularly drunk alcoholic beverages?
 Yes No

Estimated number of years? _____

Over the entire time you drank, what was your average number of drinks per week? (1 drink = 12 oz beer, 5 oz wine or 1-1/2 oz liquor)
 0-2 3-7
 8-15 15 or more

If you were drinking alcoholic beverages as of one month ago, what was your average number of drinks per week?
 0-2 3-7
 8-15 15 or more

Please check box if you have ever:

- Regularly used recreational drugs?
- Felt you should cut down on your drinking or drug use?
- Felt annoyed by others criticizing your drinking or drug use?
- Felt bad or guilty about your drinking or drug use?
- Had a drink first thing in the morning to steady your nerves to get rid of a hangover?

Check all that apply:

Is your diet restricted in any way? Yes No
(If yes, describe): _____

How many times a week do you engage in vigorous sports activities or exercises?
 Less than once Once
 2-3 4-6 7 or more

Please describe activity (frequency & duration): _____

How many hours per week do you engage in such vigorous activity?
 Less than one 1-2
 2-3 4-6 7 or more

Do you wear seat belts while driving and riding in a motor vehicle?
 Never
 Less than 50% of the time
 50-75% of the time
 More than 75% of the time
 Always

Do you practice safe sex? Yes No

What are your sleep practices? _____

Do you have emotional stress?
 Work Family Other _____

OCCUPATIONAL HISTORY

Check any previous occupations you have had:

- | | | | | |
|---|--|---|--|--|
| <input type="checkbox"/> Farmer | <input type="checkbox"/> Insulator | <input type="checkbox"/> Textile Worker | <input type="checkbox"/> Quarry Worker | <input type="checkbox"/> Military Service |
| <input type="checkbox"/> Miner | <input type="checkbox"/> Foundry Work | <input type="checkbox"/> Petrochemical Work | <input type="checkbox"/> Furniture Maker | <input type="checkbox"/> Construction Work |
| <input type="checkbox"/> Mechanical/Machinist | <input type="checkbox"/> Lumber/Paper Work | <input type="checkbox"/> Shipyard Worker | <input type="checkbox"/> Sandblaster | <input type="checkbox"/> Degreaser |
| <input type="checkbox"/> Painter | <input type="checkbox"/> None of the above | <input type="checkbox"/> Other (list) _____ | | |

Check any previous exposure to toxic or dangerous materials:

- | | | | |
|---|---|-------------------------------------|---|
| <input type="checkbox"/> Beryllium | <input type="checkbox"/> Welding fumes | <input type="checkbox"/> Noise | <input type="checkbox"/> Rubber/Plastics (type) _____ |
| <input type="checkbox"/> Sulfur Dioxide | <input type="checkbox"/> Radiation | <input type="checkbox"/> Lead | <input type="checkbox"/> Caustics (e.g., acids, bases) |
| <input type="checkbox"/> Arsenic | <input type="checkbox"/> Talc | <input type="checkbox"/> Fluoride | <input type="checkbox"/> Repeated Physical Trauma |
| <input type="checkbox"/> Mercury | <input type="checkbox"/> Asbestos | <input type="checkbox"/> Silica | <input type="checkbox"/> Other Irritant gases/fumes |
| <input type="checkbox"/> Benzene | <input type="checkbox"/> Chlorine Gases | <input type="checkbox"/> Chemicals | <input type="checkbox"/> Pesticides or Related Chemicals |
| <input type="checkbox"/> Insulation | <input type="checkbox"/> Dyes | <input type="checkbox"/> Animals | <input type="checkbox"/> Other Oils or Machining Fluid |
| <input type="checkbox"/> Other Solvents | <input type="checkbox"/> Other metals | <input type="checkbox"/> Other Dust | <input type="checkbox"/> Other Man-made Fibers (e.g., Wool) |

Current Employment

Name of Agency or Company		Division	Bureau
Job Title		Description of Duties	
Duration of Employment	Safety Equipment Used	Adverse Health Effects Possibly Job-Related	

Most Recent Previous Employment (whether within or outside current agency)

Name of Agency or Company		Division	Bureau
Job Title		Description of Duties	
Duration of Employment	Safety Equipment Used	Adverse Health Effects Possibly Job-Related	

Previous Employment

Name of Agency or Company		Division	Bureau
Job Title		Description of Duties	
Duration of Employment	Safety Equipment Used	Adverse Health Effects Possibly Job-Related	
Safety Equipment Used in Current Position? <input type="checkbox"/> Respirator <input type="checkbox"/> Dust Mask <input type="checkbox"/> Hearing Protections <input type="checkbox"/> Hard Hats <input type="checkbox"/> SCBA <input type="checkbox"/> Safety Glasses/Goggles <input type="checkbox"/> Safety Boots with or without metatarsal guards			
Are you limited in your ability to wear any personal protective equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you wear prescription glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last eye examination: _____			
Do you wear contacts <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type? _____			
Does anyone in your family work with hazardous materials (asbestos, lead, any others)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever lived near a: <input type="checkbox"/> Plant <input type="checkbox"/> Waste Site <input type="checkbox"/> Mine <input type="checkbox"/> Other facility that may have released hazardous materials			
Any other exposures to hazardous materials? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Signature of Individual Completing History Form _____ Date _____

Signature of Physician Reviewing Form _____ Date _____