Washington State Department of Labor & Industries
Division of Occupational Safety and Health

DOSH Medical Evaluation Questionnaire from WAC 296-842-22005

Instructions:

Employers:

- This questionnaire meets the requirements for WAC 296-842-14005.
- 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 employee's questionnaires.

Health Care Providers:

- 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 responses 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.

Employees:

- 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.

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 (check one) ☐ Male ☐ Female	5. Your height (in feet & inches)	6. Your weight (in pounds)
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?		
11. Check the type of respirator(s) you will be using: a. N, R, or P filtering face piece respirator (for example: a dusk mask **OR** an N95 filtering face piece respirator.		
b. ☐ Half mask ☐ Full face piece mask ☐ Helmet hood ☐ Escape ☐ Non powdered cartridge or canister ☐ Powered air purifying cartridge respirator (PAPR) ☐ Supplied-air ☐ Air-line Self-contained breathing apparatus (SCUBA) ☐ Demand ☐ Pressure demand		
12. Have you previously worn a respirator? ☐ Yes ☐ No If "Yes", describe what type(s):		

Part 2 – General Health Information

All employees must complete this part. Please check "Yes" or "No".

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

	Yes	No
5. Have you *ever had* any of the following cardiovascular or heart problems?		
a. Heart attack	☐	☐
b. Stroke	☐	☐
c. Angina	☐	☐
d. Heart failure	☐	☐
e. Swelling in your legs or feet (not caused by walking)	☐	☐
f. Heart arrhythmia (heart beating irregularly)	☐	☐
g. High blood pressure	☐	☐
h. Any other heart problem that you have been told about	☐	☐
6. Have you *ever had* any of the following cardiovascular or heart symptoms?		
a. Frequent pain or tightness in your chest	☐	☐
b. Pain or tightness in your chest during physical activity	☐	☐
c. Pain or tightness in your chest that interferes with your job	☐	☐
d. In the past 2 years, have you noticed your heart skipping or missing a beat?	☐	☐
e. Heartburn or indigestion that is not related to eating	☐	☐
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?		
a. Breathing or lung problems	☐	☐
b. Heart trouble	☐	☐
c. Blood pressure	☐	☐
d. Seizures (fits)	☐	☐
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 box at the end of this question and go to Question 9).	☐	
a. Eye irritation	☐	☐
b. Skill allergies or rashes	☐	☐
c. Anxiety	☐	☐
9. Would you like to talk to the health care professional who will review this questionnaire about your answers?	☐	☐

Part 3 – Additional Questions for Users of Full-Facepiece Respirators or SCBA

Please check "Yes" or "No".

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

Part 4 – Discretionary Questions

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

	Yes	No
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?	☐	☐
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?	☐	☐
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?	☐	☐
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	☐	☐
b. Silica (for example: in sandblasting)	☐	☐
c. Tungsten/cobalt (for example: grinding or welding this material)	☐	☐
d. Beryllium	☐	☐
e. Aluminum	☐	☐
f. Coal (for example: mining)	☐	☐
g. Iron	☐	☐
h. Tin	☐	☐
i. Dusty environments	☐	☐
j. Any other hazardous exposures?	☐	☐
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?	☐	☐
If "Yes", were you exposed to biological or chemical agents (either in training or in combat)?	☐	☐
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 in this questionnaire, are you taking any other medication for any reason (including over-the-counter medications)?	☐	☐
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	☐	☐
b. Canisters (for example: gas masks)	☐	☐
c. Cartridges	☐	☐
11. How often are you expected to use the respirator(s)?		
a. Escape-only (no rescue)	☐	☐
b. Emergency rescue only	☐	☐
c. Less than 5 hours *per week*	☐	☐
d. Less than 2 hours *per day*	☐	☐
e. 2 to 4 hours per day	☐	☐
f. Over 4 hours per day	☐	☐
12. During the period you are using the respirator(s), is your work effect:		
a. *Light* (less than 200 kcal per hour)	☐	☐
If "Yes", how long does this period last during the average shift: _____ hours _____ minutes		
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.		
b. *Moderate* (200 to 350 kcal per hour)	☐	☐
If "Yes", how long does this period last during the average shift: _____ hours _____ minutes		
Examples of moderate work effort: 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 kcal per hour)	☐	☐
If "Yes", how long does this period last during the average shift: _____ hours _____ minutes		
Examples of heavy work: 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 casting, walking up an 8-degree grade about 2 mph, climbing stairs with a heavy load (about 50 lbs.)		
13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you are using your respirator?	☐	☐
If "Yes", describe this protective clothing and/or equipment.		

	Yes	No
14. Will you be working under hot conditions (temperature exceeding 77°F)?	☐	☐
15. Will you be working under humid conditions?	☐	☐

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 per shift: _____

Duration of exposure per shift: _____

Name of the second toxic substance: _____

Estimated maximum exposure per shift: _____

Duration of exposure per shift: _____

Name of the third toxic substance: _____

Estimated maximum exposure 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).

[Statutory Authority: RCW 49.17.010, .040, .050, and .060. 17-18-075 (Order 16-17), § 296-842-22005, filed 09/05/2017, effective 10/06/2017. Statutory Authority: RCW 49.17.050. 09-19-119 (Order 09-02), § 296-842-22005, filed 09/22/09, effective 12/01/09. Statutory Authority: RCW 49.17.010, .040, .050, and .060. 07-05-072 (Order 06-39), § 296-842-22005, filed 02/20/07, effective 04/01/07. Statutory Authority: RCW 49.17.010, .040, .050, and .060. 03-20-114 (Order 02-12), § 296-842-22005, filed 10/01/03, effective 01/01/04.]

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