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| L&I DOSH Logo | **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.

|  |  |  |
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| 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 facepiece respirator (for example: a dusk mask **OR** an N95 filtering facepiece respirator. |
| b.  | [ ]  Half mask | [ ]  Full facepiece mask | [ ]  Helmet hood | [ ]  Escape |
|  | [ ]  Nonpowdered 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 [ ]  NoIf “Yes”, describe what type(s): |

**Part 2 — General Health Information**

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

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|  | **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? |
| 1. Seizures (fits)
 | [ ]  | [ ]  |
| 1. Diabetes (sugar disease)
 | [ ]  | [ ]  |
| 1. Allergic reactions that interfere with your breathing
 | [ ]  | [ ]  |
| 1. Claustrophobia (fear of closed-in places)
 | [ ]  | [ ]  |
| 1. Trouble smelling odors
 | [ ]  | [ ]  |
| 3. Have you *ever had* any of the following pulmonary or lung problems? |
| 1. Asbestosis
 | [ ]  | [ ]  |
| 1. Asthma
 | [ ]  | [ ]  |
| 1. Chronic bronchitis
 | [ ]  | [ ]  |
| 1. Emphysema
 | [ ]  | [ ]  |
| 1. Pneumonia
 | [ ]  | [ ]  |
| 1. Tuberculosis
 | [ ]  | [ ]  |
| 1. Silicosis
 | [ ]  | [ ]  |
| 1. Pneumothorax (collapsed lung)
 | [ ]  | [ ]  |
| 1. Lung cancer
 | [ ]  | [ ]  |
| 1. Broken ribs
 | [ ]  | [ ]  |
| 1. Any chest injuries or surgeries
 | [ ]  | [ ]  |
| 4. Do you *currently* have any of the following symptoms of pulmonary or lung illness? |
| 1. Shortness of breath
 | [ ]  | [ ]  |
| 1. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
 | [ ]  | [ ]  |
| 1. Shortness of breath when walking with other people at an ordinary pace on level ground
 | [ ]  | [ ]  |
| 1. Have to stop for breath when walking at your own pace on level ground
 | [ ]  | [ ]  |
| 1. Shortness of breath when washing or dressing yourself
 | [ ]  | [ ]  |
| 1. Shortness of breath that interferes with your job
 | [ ]  | [ ]  |
| 1. Coughing that produces phlegm (thick sputum)
 | [ ]  | [ ]  |
| 1. Coughing that wakes you early in the morning
 | [ ]  | [ ]  |
| 1. Coughing that occurs mostly when you are lying down
 | [ ]  | [ ]  |
| 1. Coughing up blood in the last month
 | [ ]  | [ ]  |
| 1. Wheezing
 | [ ]  | [ ]  |
| 1. Wheezing that interferes with your job
 | [ ]  | [ ]  |
| 1. Chest pain when you breath deeply
 | [ ]  | [ ]  |
| 1. Any other symptom that you think may be related to lung problems
 | [ ]  | [ ]  |

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|  | **Yes** | **No** |
| 5. Have you *ever had* any of the following cardiovascular or heart problems? |
| 1. Heart attack
 | [ ]  | [ ]  |
| 1. Stroke
 | [ ]  | [ ]  |
| 1. Angina
 | [ ]  | [ ]  |
| 1. Heart failure
 | [ ]  | [ ]  |
| 1. Swelling in your legs or feet (not caused by walking)
 | [ ]  | [ ]  |
| 1. Heart arrhythmia (heart beating irregularly)
 | [ ]  | [ ]  |
| 1. High blood pressure
 | [ ]  | [ ]  |
| 1. Any other heart problem that you have been told about
 | [ ]  | [ ]  |
| 6. Have you *ever had* any of the following cardiovascular or heart symptoms? |
| 1. Frequent pain or tightness in your chest
 | [ ]  | [ ]  |
| 1. Pain or tightness in your chest during physical activity
 | [ ]  | [ ]  |
| 1. Pain or tightness in your chest that interferes with your job
 | [ ]  | [ ]  |
| 1. In the past 2 years, have you noticed your heart skipping or missing a beat?
 | [ ]  | [ ]  |
| 1. Heartburn or indigestion that is not related to eating
 | [ ]  | [ ]  |
| 1. 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? |
| 1. Breathing or lung problems
 | [ ]  | [ ]  |
| 1. Heart trouble
 | [ ]  | [ ]  |
| 1. Blood pressure
 | [ ]  | [ ]  |
| 1. 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). | [ ]  |  |
| 1. Eye irritation
 | [ ]  | [ ]  |
| 1. Skill allergies or rashes
 | [ ]  | [ ]  |
| 1. 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”.

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|  | **Yes** | **No** |
| 1. Have your *ever lost* vision in either eye (temporarily or permanently)? | [ ]  | [ ]  |
| 2. Do you *currently* have any of these vision problems? |  |  |
| 1. Need to wear contact lenses
 | [ ]  | [ ]  |
| 1. Need to wear glasses
 | [ ]  | [ ]  |
| 1. Color blindness
 | [ ]  | [ ]  |
| 1. Any other eye or vision problems
 | [ ]  | [ ]  |
| 3. Have you *ever had* an injury to your ears including a broken ear drum? | [ ]  | [ ]  |
| 4. Do you *currently* have any of these hearing problems? | [ ]  | [ ]  |
| 1. Difficulty hearing
 | [ ]  | [ ]  |
| 1. Need to wear a hearing aid
 | [ ]  | [ ]  |
| 1. 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? |
| 1. Weakness in any of your arms, hands, legs, or feet
 | [ ]  | [ ]  |
| 1. Back pain
 | [ ]  | [ ]  |
| 1. Difficulty fully moving your arms and legs
 | [ ]  | [ ]  |
| 1. Pain or stiffness when you forward or backward at the waist
 | [ ]  | [ ]  |
| 1. Difficulty fully moving your head up and down
 | [ ]  | [ ]  |
| 1. Difficulty fully moving your head side to side
 | [ ]  | [ ]  |
| 1. Difficulty bending at your knees
 | [ ]  | [ ]  |
| 1. Difficulty squatting to the ground
 | [ ]  | [ ]  |
| 1. Climbing a flight of stairs or a ladder carrying more than 25 lbs.
 | [ ]  | [ ]  |
| 1. 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.

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|  | **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: |
| 1. Asbestos
 | [ ]  | [ ]  |
| 1. Silica (for example: in sandblasting)
 | [ ]  | [ ]  |
| 1. Tungsten/cobalt (for example: grinding or welding this material)
 | [ ]  | [ ]  |
| 1. Beryllium
 | [ ]  | [ ]  |
| 1. Aluminum
 | [ ]  | [ ]  |
| 1. Coal (for example: mining)
 | [ ]  | [ ]  |
| 1. Iron
 | [ ]  | [ ]  |
| 1. Tin
 | [ ]  | [ ]  |
| 1. Dusty environments
 | [ ]  | [ ]  |
| 1. 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 combat)? | [ ]  | [ ]  |
| 8. Have you ever worked on a HAZMAT team? | [ ]  | [ ]  |

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|  | **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)? |
| 1. HEPA filters
 | [ ]  | [ ]  |
| 1. Canisters (for example: gas masks)
 | [ ]  | [ ]  |
| 1. Cartridges
 | [ ]  | [ ]  |
| 11. How often are you expected to use the respirator(s)? |
| 1. Escape-only (no rescue)
 | [ ]  | [ ]  |
| 1. Emergency rescue only
 | [ ]  | [ ]  |
| 1. Less than 5 hours *per week*
 | [ ]  | [ ]  |
| 1. Less than 2 hours *per day*
 | [ ]  | [ ]  |
| 1. 2 to 4 hours per day
 | [ ]  | [ ]  |
| 1. Over 4 hours per day
 | [ ]  | [ ]  |
| 12. During the period you are using the respirator(s), is your work effect: |
| 1. *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. |
| 1. *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 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. |
| 1. *Heavy* (above kcal per hour)
 | [ ]  | [ ]  |
| If “Yes”, how long does this period last during the average shift: \_\_\_\_\_\_\_\_\_\_ hours \_\_\_\_\_\_\_\_\_\_ minutes |
| 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 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.]