

Lansing Community College Respirator Medical Evaluation Questionnaire

- **Standard Number:** 29CFR1910.134 Appendix C
- **Standard Title:** OSHA Respirator Medical Evaluation Questionnaire (Mandatory)
- **Subpart Number:** I
- **Subpart Title:** Personal Protective Equipment

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

To the Physician:

The answers to these questions should guide your physical exam for this individual. They will be challenged physically and mentally during the Lansing Community College’s Regional Fire Training Academy. They will be required to lift and carry bodies; lift and carry ladders; lift and carry auto extrication equipment; work in an environment over 300 F°; rain; cold; wind; snow; and ice. They will be required to do this work with approximately 75 lbs. of equipment on them for up to four (4) hours each day.

To the Recruit:

Can you read (circle one): Yes/No

You must have your Physician or other Licensed Health Care Professional (PLHCP) review this form with you.

Part A. Section 1. (Mandatory) The following information must be provided by every recruit who will enter into the Lansing Community College Fire Academy Program and use a Self Contained Breathing Apparatus (SCBA).

Please print legibly when completing this form.

1. Today’s date: _____

2. Your name: _____

3. Your age: _____

4. Sex (circle one): Male/Female

5. Your height: _____ ft. _____ in.

6. Your weight: _____ lbs.

7. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____

8. The best time to phone you at this number: _____

9. Your PLHCP has reviewed this form with you? (circle one) Yes/No

10. The type of respirator you will be using is: A open circuit SCBA.

11. Have you ever worn a respirator (circle one): Yes/No

If “yes,” what type(s):

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every recruit who will be using any type of respirator (please circle “yes” or “no”).

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month: Yes/No

2. Have you **ever had** any of the following conditions?

- 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 places): Yes/No
- e. Trouble smelling odors: Yes/No

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

- 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 (collapsed lung): 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: Yes/No

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?
 - 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: Yes/No

5. Have you **ever had** any of the following cardiovascular or heart problems?
 - 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 about: Yes/No

6. Have you **ever had** any of the following cardiovascular or heart symptoms?
 - 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: Yes/No

7. Do you **currently** take medication for any of the following problems?
 - a. Breathing or lung problems: Yes/No
 - b. Heart trouble: Yes/No
 - c. Blood pressure: Yes/No
 - d. Seizures (fits): Yes/No

8. If you've used a respirator, have you **ever had** any of the following problems? (If you've never used a respirator, answer (a) no and go to question 9):
 - a. Have you ever used a respirator: Yes/No

- b. Eye irritation: Yes/No
- c. Skin allergies or rashes: Yes/No
- d. Anxiety: Yes/No
- e. General weakness or fatigue: Yes/No
- f. Any other problem that interferes with your use of a respirator: Yes/No

You must answer Questions 9 – 14.

9. Have you **ever lost** vision in either eye (temporarily or permanently): Yes/No
10. Do you **currently** have any of the following vision problems?
- a. Wear contact lenses: Yes/No
 - b. Wear glasses: Yes/No
 - c. Color blind: Yes/No
 - d. Any other eye or vision problem: Yes/No
11. Have you **ever had** an injury to your ears, including a broken ear drum: Yes/No
12. Do you **currently** have any of the following hearing problems?
- a. Difficulty hearing: Yes/No
 - b. Wear a hearing aid: Yes/No
 - c. Any other hearing or ear problem: Yes/No
13. Have you **ever had** a back injury: Yes/No
14. Do you **currently** have any of the following musculoskeletal problems?
- 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. Difficulty 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 25 lbs: Yes/No
 - j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

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 feelings 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:
- 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: Yes/No

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: Yes/No

If “yes” were you exposed to biological or chemical agents (either in training or combat):
Yes/No

8. Have you 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 medications for any reason (including over-the-counter medications): Yes/No

If “yes” name the medications if you know them: _____

10. You will be expected to use the respirator up to 4 hours per day.
11. During the period you are using your respirator in your class your work effort is considered **Heavy** (above 350 kcal per hour).

Examples of heavy work are **lifting** a heavy load (about 50 lbs or more) from the floor to your waist or shoulder; climbing stairs with a heavy load (about 50 lbs or more).

12. You will be wearing protective clothing and/or equipment (other than the respirator) when you are using your respirator. Full firefighter turn out gear – coat, pants, boots, hood, gloves and helmet on top of street clothes with the SCBA.
13. You will be working under hot conditions (temperature exceeding 77 deg. F).
14. You will be working under humid conditions.
15. The work and any special or hazardous conditions you might encounter while using your respirator are: climbing ladders, confined spaces, fire suppression activities, hazardous material suits, carrying victims, chopping holes with an axe on slanted roofs.
16. The following information, is about the toxic substances that you'll be exposed to when you're using your respirator:

Name of toxic substance: **Carbon Monoxide**

Estimated maximum exposure level per training session: **1,000 ppm**

Duration of exposure per training session: **10 minutes**

Name of toxic substance: **ABC Fire Extinguisher Powder**

Estimated maximum exposure level per training session: **550 ppm**

Duration of exposure per training session: **10 minutes**

Name of toxic substance: **Smoke**

Estimated maximum exposure level per training session: **1,000 ppm**

Duration of exposure per training session: **10 minutes**

The names of other toxic substances that you'll be exposed to while using your respirator: Class B Foam, Gasoline, Fuel Oil, Bar Chain Oil, Bleach, Hydraulic Oil, Anti-Fog solution for SCBA mask

17. Describe any special responsibilities you'll have while using your respirator that may affect the safety and well-being of others: **Rescue and Fire Suppression Activities.**

Recruit Signature

Date

Licensed Health Care Professional Signature

Date

To The Licensed Health Care Professional:

The student must submit this completed questionnaire form in with his/her completed physical form to Nancy Ziegler in Enrollment Services Room 2200 in Gannon Vocational Technical Building at Lansing Community College, along with the application packet.

This form must accompany the application packet as well as the signed and dated physical form.