O-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

NON-DHS/NON-COUNTY WORKFORCE MEMBER
8 CCR SECTION 5144 – APPENDIX C
RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Questionnaire for respirators greater than N95

☞ **GENERAL INFORMATION on last page**

WORKFORCE MEMBER TO COMPLETE ONCE EVERY FOUR (4) YEARS OR AS NEEDED

To the EMPLOYER:
Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the WORKFORCE MEMBER:
Can you read and understand this questionnaire (check one): ☐ Yes ☐ No

Your employer must allow you to answer the 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.

Reset Form

SECTION 1 – PART A (MANDATORY)

The following information must be provided by every workforce member who has been selected to use any type of respirator.

PLEASE PRINT LEGIBLY

TODAY'S DATE:			
LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	GENDER ☐ MALE ☐ FEMALE
HEIGHT FT IN	WEIGHT LBS	JOB TITLE	HSN NO.
PHONE NUMBER	Best Time to reach you?	Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No	

Check type of respirator you will use (you can check more than one category):
☐ N, R, Or P disposal respirator (filter-mask, non-cartridge type only)
☐ Other type (specify): _____

Have you worn a respirator? ☐ Yes ☐ No	If "yes", what type:

SECTION 2 – PART A (MANDATORY)

Questions 1 through 9 below must be answered by every workforce member who has been selected to use any type of respirator (please check "YES," "NOT SURE," or "NO").

YES	NOT SURE	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

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	HSN NO.

YES	NOT SURE	NO	
			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
☐	☐	☐	l. Any other lung problem that you've been told about?
			If "YES," please explain:
			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
☐	☐	☐	m. Chest pain when you breathe deeply
☐	☐	☐	n. Any other symptoms that you think may be related to lung problems?
			If "YES," please list symptoms:
			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've been told about?
			If "YES," please explain:

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	HSN NO.

YES	NOT SURE	NO	
			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 two 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? If "YES," please list symptoms:
			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've ever used a respirator, have you ever had any of the following problems?
☐	☐	☐	a. Eye irritation
☐	☐	☐	b. Skin allergies or rashes
☐	☐	☐	c. Anxiety
☐	☐	☐	d. General weakness or fatigue
☐	☐	☐	e. Any other problem that interferes with your use of a respirator? If "YES," please explain:
☐	☐	☐	9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

SECTION 2 – PART B ☐ NOT APPLICABLE

Questions 10 through 15 below must be answered by every workforce member who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For workforce members who have been selected to use other types of respirators, answering these questions is **VOLUNTARY.**

YES	NOT SURE	NO	
☐	☐	☐	10. Have you ever lost vision in either eye (temporarily or permanently)?
			11. Do you currently have any of the following vision problems:
☐	☐	☐	a. Wear contact lenses
☐	☐	☐	b. Wear glasses
☐	☐	☐	c. Color blind
☐	☐	☐	d. Any other eye or vision problem? If "YES," please explain:
☐	☐	☐	12. Have you ever had an injury to your ears, including a broken ear drum?

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	HSN NO.

YES	NOT SURE	NO	
			13. Do you currently have any of the following hearing problem:
☐	☐	☐	a. Difficulty hearing
☐	☐	☐	b. Wear a hearing aid
☐	☐	☐	c. Any other hearing or ear problem
			If "YES," please explain:
☐	☐	☐	14. Have you ever had a back injury?
			15. 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 and stiffness when you lean forward or backward at the waist
☐	☐	☐	e. Difficulty fully moving your head up or 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 problem that interferes with using a respirator?
			If "YES," please explain:

SECTION 2 – PART C ☐ NOT APPLICABLE

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.

YES	NOT SURE	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're working under these conditions?
☐	☐	☐	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.
			If "YES," name the chemicals if you know them: a. _____ d. _____ b. _____ e. _____ c. _____ f. _____
			3. Have you ever worked with any of the materials, or under any of the conditions, listed below:
☐	☐	☐	a. Asbestos
☐	☐	☐	b. Silica (e.g., in sandblasting)
☐	☐	☐	c. Tungsten/cobalt (e.g., grinding or welding this material)
☐	☐	☐	d. Beryllium
☐	☐	☐	e. Aluminum

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	HSN NO.

YES	NOT SURE	NO	
☐	☐	☐	f. Coal (for example, mining)
☐	☐	☐	g. Iron
☐	☐	☐	h. Tin
☐	☐	☐	i. Dusty environment
☐	☐	☐	j. Any other hazardous exposures? If "YES," describe these exposure:
			4. List any second jobs or side businesses you have: a. _____ d. _____ b. _____ e. _____ c. _____ f. _____
			5. List your previous occupations: a. _____ d. _____ b. _____ e. _____ c. _____ f. _____
			6. List your current and previous hobbies: a. _____ d. _____ b. _____ e. _____ c. _____ f. _____
☐	☐	☐	7. Have you been in the military services?
☐	☐	☐	If "YES," were you exposed to biological or chemical agents (either in training or combat)? Please list chemicals (if known): a. _____ d. _____ b. _____ e. _____ c. _____ f. _____
☐	☐	☐	8. Have you ever worked on a HAZMAT team?
☐	☐	☐	9. Other than medications for breathing and lung problems, heart troubles, 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 if you know them: a. _____ e. _____ b. _____ f. _____ c. _____ g. _____ d. _____ h. _____
			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)? Check "YES", "NOT SURE," or "NO" to all answers that apply to you.

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	HSN NO.

YES	NOT SURE	NO	
☐	☐	☐	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 effort: a. Light (less than 200 kcal per hour) If "YES," how long does this period last during the average shift:_____hrs. _____mins. *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.*
☐	☐	☐	b. Moderate (200 to 350 kcal per hour) If "YES," how long does this period last during the average shift:_____hrs. _____mins. *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.*
☐	☐	☐	c. Heavy (above 350 kcal per hour) If "YES," how long does this period last during the average shift:_____hrs. _____mins. *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.).*
☐	☐	☐	13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using the respirator? If "YES," describe this protective clothing and/or equipment: a. _____ e. _____ b. _____ f. _____ c. _____ g. _____ d. _____ h. _____
☐	☐	☐	14. Will you be working under hot conditions (temperature exceeding 77 degrees Fahrenheit)?
☐	☐	☐	15. Will you be working under humid conditions?

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):

CONTINUE ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	HSN NO.

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 toxic substances	Estimated maximum exposure level per shift:	Duration of exposure per shift
a.	a.	a.
b.	b.	b.
c.	c.	c.
d.	d.	d.
e.	e.	e.
f.	f.	f.

The name of any other toxic substances that you'll be exposed to while using your respirator(s):

19. 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):

Workforce Member Signature	Date

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

FOR COMPLETION BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL
PROVIDE A COPY OF THIS PAGE TO THE WORKFORCE MEMBER

PART 1: Fit Testing Recommendation – Based on Questionnaire

☐ Questionnaire above reviewed.
☐ Medical approval to receive Fit Test:
1. ☐ Disposable Particulate Respirators (N-95)
2. ☐ Replaceable Disposable Particulate Respirator ☐ a. Half-Facepiece ☐ b. Full Facepiece
3. ☐ Powered Air-Purifying Respirators (PAPRs) ☐ a. Tight Fitting
4. ☐ Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

☐ The above workforce member has not been cleared to be fit tested for a respirator.
- ☐ Additional medical evaluation is needed. Physician or Licensed Health Care Professional to complete Part 2 below.
- ☐ Medically unable to use a respirator.

☐ Informed workforce member of the results of this examination.

Comments: _____

PART 2: Additional Medical Evaluations ☐ Not Applicable

☐ Medical evaluation completed.
☐ Medical Approval to Receive Fit Test:
1. ☐ Disposable Particulate Respirators (N-95)
2. ☐ Replaceable Disposable Particulate Respirator ☐ a. Half-Facepiece ☐ b. Full Facepiece
3. ☐ Powered Air-Purifying Respirators (PAPRs) ☐ a. Tight Fitting
4. ☐ Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

☐ Medically unable to use a respirator.

☐ Informed workforce member of the results of this examination.

Comments: _____

Physician or Licensed Health Care Professional Signature	Print Name	License No.	Date
Facility Name/Address		Phone No.	
Workforce Member Signature		Date	

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	HSN NO.

DHS-EHS OFFICE STAFF ONLY			
Completion of this form:	Reviewed By (Print)	Signature	Date

GENERAL INFORMATION

THIS QUESTIONNAIRE IS TO BE REVIEWED BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL.

8 CCR §5144

1. General. DHS-EHS or non-DHS/non-County workforce member's (WFM) School/Employer shall provide a medical evaluation to determine the WFM ability to use a respirator, before the WFM is fit tested or required to use the respirator in the workplace. DHS-EHS may discontinue a WFM's medical evaluations when the WFM is no longer required to use a respirator.
2. Medical evaluation procedures.
   a. DHS-EHS or non-DHS/non-County WFM School/Employer shall identify a physician or other licensed health care professional (PLHCP) to perform medical evaluations using a medical questionnaire or an initial medical examination that obtains the same information as the medical questionnaire.
   b. The medical evaluation shall obtain the information requested by this questionnaire in Sections 1 and 2, Part
3. Follow-up medical examination.
   a. DHS-EHS or non-DHS/non-County WFM School/Employer shall ensure that a follow-up medical examination is provided for a non-DHS/non-County WFM who gives a **positive response to any question among questions 1 through 8 in Section 2, Part A** of this questionnaire or whose initial medical examination demonstrates the need for a follow-up medical examination.
   b. The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the PLHCP deems necessary to make a final determination.

If WFM is unable to be fit-tested or has failed the fit test, WFM must be provided with a powered air-purifying respirator (PAPR).

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non-DHS/non-County WFM School/Employer. The School/Employer shall verify completeness of DHS-EHS form(s) and ensure confidentiality of non-DHS/non-County WFM health information.

Upon request by DHS-Employee Health Services (EHS), the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hour. All non-DHS/non-County workforce member health records are confidential in accordance with federal, state and regulatory requirements.

Health records will be maintained by DHS-EHS or non-County WFM School/Employer and kept for thirty (30) years after the workforce member's employment/assignment ends, in accordance with State and Federal medical records standards and DHS policies and procedures.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing medical information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.

A copy of the respiratory protection regulation Title 8 CCR §5144 and §5199 can be found at http://www.dir.ca.gov/title8/5144.html and http://www.dir.ca.gov/Title8/5199.html