WAC 296-842-22005 Use this medical questionnaire for medical evaluations. Use the medical questionnaire in Table 10 when conducting medical evaluations.

Note:
1. You may use a physical exam instead of this questionnaire if the exam covers the same information as the questionnaire.
2. You may use online questionnaires if the questions are the same and the requirements in WAC 296-842-14005 of this chapter are met.
3. You may choose to send the questionnaire to the LHCP ahead of time, giving time to review it and add any necessary questions.
4. The LHCP determines what questions to add to the questionnaire, if any; however, questions in Parts 1-3 may not be deleted or substantially altered.

Table 10

DOSH Medical Evaluation Questionnaire
Employer instructions:
• You may use online questionnaires if the requirements in WAC 296-842-14005 are met. • 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 employees' questionnaires.
Health care provider's instructions:
• 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 response 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.
Employee information and instructions:
• 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 (circle one): Male / Female
5. Your height: _____ft. ____in.
6. Your weight: _____lbs.
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? Yes / No
11. Check the type of respirator(s) you will be using:

a. ___ N, R, or P filtering-facepiece respirator (for example, a dust mask, OR an N95 filtering-facepiece respirator).

b. Check all that apply.
□ Half mask □ Full facepiece mask □ Helmet hood □ Escape
□ Nonpowered cartridge or canister □ Powered air-purifying cartridge respirator (PAPR)
□ Supplied-air or Air-line
Self contained breathing apparatus (SCBA): □ Demand or □ Pressure demand
Other: _____

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 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 problem that you have 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?	Yes	/	No
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 have 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 2 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?	Yes	/	No
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 have used a respirator, have you *ever had* any of the following problems? (If you have never used a respirator, check the following space and go to question 9:)			
a. Eye irritation:	Yes	/	No
b. Skin allergies or rashes:	Yes	/	No
c. Anxiety:	Yes	/	No
d. General weakness or fatigue:	Yes	/	No
e. Any other problem that interferes with your use of a respirator?	Yes	/	No
9. Would you like to talk to the health care professional who will review this questionnaire about your answers?	Yes	/	No
Part 3 - Additional Questions for Users of Full-Facepiece Respirators or SCBAs			
Please circle "Yes" or "No"			
1. Have you *ever lost* vision in either eye (temporarily or permanently)?	Yes	/	No
2. Do you *currently* have any of these vision problems?			
a. Need to wear contact lenses:	Yes	/	No
b. Need to wear glasses:	Yes	/	No
c. Color blindness:	Yes	/	No
d. Any other eye or vision problem:	Yes	/	No
3. Have you *ever had* an injury to your ears, including a broken ear drum?	Yes	/	No
4. Do you *currently* have any of these hearing problems?			
a. Difficulty hearing:	Yes	/	No
b. Need to wear a hearing aid:	Yes	/	No
c. Any other hearing or ear problem:	Yes	/	No
5. Have you *ever had* a back injury?	Yes	/	No
6. 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 4 - Discretionary Questions

Complete questions in this part ONLY IF your employer's health care provider says they are necessary

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 are working under these conditions:	Yes	/	No
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?	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 (for example, in sandblasting)?	Yes	/	No
c. Tungsten/cobalt (for example, 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 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 medications for any reason (including over-the-counter medications)?	Yes	/	No
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:	Yes	/	No
b. Canisters (for example, gas masks):	Yes	/	No
c. Cartridges:	Yes	/	No
11. How often are you expected to use the respirator(s)?			
a. Escape-only (no rescue):	Yes	/	No
b. Emergency rescue only:	Yes	/	No
c. Less than 5 hours *per week*:	Yes	/	No
d. Less than 2 hours *per day*:	Yes	/	No
e. 2 to 4 hours per day:	Yes	/	No
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):	Yes	/	No

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): Yes / No

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): Yes / No

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 are using your respirator? Yes / No

If "yes," describe this protective clothing and/or equipment: _____

14. Will you be working under hot conditions (temperature exceeding 77°F): Yes / No

15. Will you be working under humid conditions: Yes / No

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 level per shift: _____

Duration of exposure per shift: _____

Name of the second toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the third toxic substance: _____

Estimated maximum exposure level 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, 49.17.040, 49.17.050, and 49.17.060. WSR 17-18-075, § 296-842-22005, filed 9/5/17, effective 10/6/17. Statutory Authority: RCW 49.17.050 and 29 C.F.R. Subpart Z. WSR 09-19-119, § 296-842-22005, filed 9/22/09, effective 12/1/09. Statutory Authority: RCW 49.17.010, 49.17.040, 49.17.050, 49.17.060. WSR 07-05-072, § 296-842-22005, filed 2/20/07, effective 4/1/07; WSR 03-20-114, § 296-842-22005, filed 10/1/03, effective 1/1/04.]