Duke University Employee Occupational Health and Wellness
QUESTIONNAIRE FOR RESPIRATOR USERS

Pharmacy Department Employees Only

The Occupational Safety and Health Administration (OSHA) requires that the following information be provided by every employee who has been selected to use any type of respirator (please print). If you have any questions regarding the first two pages, you may talk to your supervisor or call the Occupational and Environmental Safety Office (OESO) at 684-5996.

Can you read? ❑ Yes ❑ No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your supervisor must not look at or review your answers to the medical portion of this questionnaire. **When completed, this form should be sent in a sealed envelope to Employee Occupational Health and Wellness, Box 3148 Medical Center.**

Your name:_____ **Your Work Phone**:_____
Your Duke ID (If known): _____ **Daytime phone, if different**:_____
Your Department:___Pharmacy. _____**Box**#____ **Best time to call:**_____
Your Job Title:_____ **Sex**: ❑ Male ❑ Female
Supervisor's Name: _____ **Today's date**:_____

Check the type of respirator you will use in this job (you can check more than one category):

❑ N, R, or P disposable respirator (filter-mask, non-cartridge type only). (<1lb)
❑ air-purifying, half mask (< 1 lb)
❑ air-purifying, full mask (1-3 lbs)
☑ powered air-purifying hood (<4 – 12 lbs)
❑ powered air-purifying, tight fitting (< 5 lbs)
❑ supplied air, hood (<3 lbs)
❑ supplied air, tight fitting (2 –4 lbs)
❑ Self-Contained Breathing Apparatus (SCBA) (24 lbs)
❑ Other:_____

Use is ☑ Required ❑ Voluntary

Please indicate your level of work effort while using the respirator, indicating the amount of time you would spend at each level in a day:

Level of Effort		Examples
❑ light	____hours	typing, operating a drill press.
☑ moderate	___hours	Nailing, assembly work, pushing a wheelbarrow on a level surface
❑ heavy	___hours	Heavy lifting, shoveling, climbing stairs with a heavy load

How often are you expected to use the respirator?

❑ Escape only
❑ Emergency rescue only
☑ Less than 5 hours per week
❑ Daily, for less than 2 hours per day
❑ Daily, for 2 - 4 hours per day
❑ Daily, more than 4 hours per day

For Employee Occupational Health Services (EOHS) use only:

Medically approved for ❑All air-purifying respirators ❑Supplied Air Respirators ❑SCBA
❑Other:_____

Restrictions: ❑Employee may decline respirator-requiring assignments for temporary health-related difficulties
❑Other: _____

Effective through_____OR ❑ Complete brief questionnaire at time of annual training (Required users only)

Employee has been provided with a copy of this written recommendation: ❑Yes ❑No

Signature of Physician or Other Licensed Health Care Professional:_____

(Criteria: EE has health problems – Use medical judgment; No relevant health problems: Most working conditions: indefinite clearance (20 years); Any work conditions with SCBA: 2 years from present date)

Duke ID _____ Employee Name_____

Your Age (to nearest year):_____ **Your Weight**: _____ lbs. **Your Height**: _____ ft. _____ in.

Have you worn a respirator? ❑Yes ❑No
If yes, what type(s)?_____

On the list below, please check any types of personal protective equipment you will be wearing when using your respirator. (❑ None)

☑ Gloves ❑ Hearing protection ☑ Apron or lab coat
❑ Eye protection ❑ Hard hat ❑ Full body suit PPE
❑ Other (Please describe)_____

Will you be working under hot conditions? (above 85 deg. F): ❑ Yes ❑ No
Will you be working under humid conditions? ❑ Yes ❑ No

Describe the work you'll be doing while using your respirator(s):

Cleaning and decontaminating fume hoods used for chemotherapy; possibly cleaning up a spill of powdered chemotherapy/hazardous drugs

Describe any special or hazardous conditions you might encounter when using your respirator(s) (for example, confined spaces, life-threatening gases):

_____

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 or security):

_____

_____

Provide the following information, if you know it, for each potentially hazardous substance that you'll be exposed to when using your respirator(s).

Name of potentially hazardous substance	Estimated Maximum Exposure Level	Duration of exposure (# hours/week)
Hazardous drugs residue	?	
Hazardous drugs powder spill	?	

Signature of Safety Personnel *Courtney V Stanion* _____Date _8-1-02_____

Has your employer told you how to contact the health care professional who will review this questionnaire? (Call Employee Health at 684-3136.) ❑ **Yes** ❑ **No**

Duke ID _____ Employee Name_____

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please check "yes" or "no").** Employee Occupational Health and Wellness (EOHW) at 684-3136 can assist you with this portion of the questionnaire.

	Yes	No
1. Do you <u>currently</u> smoke tobacco, or have you smoked tobacco in the last month?	❑	❑
2. Have you <u>ever had</u> any of the following conditions?		
a. Seizures	❑	❑
b. Diabetes (sugar disease)	❑	❑
c. Allergic reactions that interfere with your breathing	❑	❑
d. Claustrophobia (fear of closed-in places)	❑	❑
e. Trouble smelling odors	❑	❑
f. Heat stroke	❑	❑
3. Have you <u>ever had</u> 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	❑	❑
4. Have you <u>ever had</u> 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	❑	❑

	Yes	No
5. Do you <u>currently</u> 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 symptoms that you think may be related to lung problems	❑	❑
6. Have you <u>ever had</u> 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	❑	❑

Duke ID _____ Employee Name_____

	Yes	No
6 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 <u>currently</u> take medication for any of the following problems?		
a. Breathing or lung problems	❑	❑
b. Heart trouble	❑	❑
c. Blood pressure	❑	❑
d. Seizures	❑	❑

****Briefly explain "Yes" answers:**

_____

_____

	Yes	No
8. If you've used a respirator, have you <u>ever had</u> any of the following problems? (If you've never used a respirator, check no on this line and go to question 9)		
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	❑	❑
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	❑	❑

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.**

	Yes	No
10. Have you <u>ever lost</u> vision in either eye (temporarily or permanently)?	❑	❑
11. Do you <u>currently</u> have any of the following vision problems?		
a. Wear contact lenses	❑	❑
b. Wear glasses	❑	❑
c. Color blind	❑	❑
d. Any other eye or vision problem	❑	❑
12. Have you <u>ever had</u> an injury to your ears, including a broken ear drum?	❑	❑
13. Do you <u>currently</u> have any of the following hearing problems?		
a. Difficulty hearing	❑	❑
b. Wear a hearing aid	❑	❑
c. Any other hearing or ear problem	❑	❑
14. Have you <u>ever had</u> a back injury?	❑	❑

****Briefly explain "Yes" answers:**

_____

_____

_____

	Yes	No
15. Do you <u>currently</u> 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 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 pounds	❑	❑
j. Any other muscle or skeletal problem that interferes with using a respirator	❑	❑