

**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):

- | | |
|---|--|
| <input checked="" type="checkbox"/> N, R, or P disposable respirator (filter-mask, non-cartridge type only). (<1lb) | <input type="checkbox"/> supplied air, hood (<3 lbs) |
| <input checked="" type="checkbox"/> air-purifying, half mask (< 1 lb) | <input type="checkbox"/> supplied air, tight fitting (2 –4 lbs) |
| <input type="checkbox"/> air-purifying, full mask (1-3 lbs) | <input type="checkbox"/> Self-Contained Breathing Apparatus (SCBA) (24 lbs) |
| <input checked="" type="checkbox"/> powered air-purifying hood (<4 – 12 lbs) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> powered air-purifying, tight fitting (< 5 lbs) | Use is <input checked="" type="checkbox"/> Required <input type="checkbox"/> 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 |
|---|--|
| <input type="checkbox"/> light ___ hours | typing, operating a drill press. |
| <input checked="" type="checkbox"/> moderate ___ hours | Nailing, assembly work, pushing a wheelbarrow on a level surface |
| <input type="checkbox"/> heavy ___ hours | Heavy lifting, shoveling, climbing stairs with a heavy load |

How often are you expected to use the respirator?

- | | |
|--|---|
| <input type="checkbox"/> Escape only | <input type="checkbox"/> Daily, for less than 2 hours per day |
| <input type="checkbox"/> Emergency rescue only | <input type="checkbox"/> Daily, for 2 - 4 hours per day |
| <input checked="" type="checkbox"/> Less than 5 hours per week | <input type="checkbox"/> 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 working 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 Robin Kirwan Date 6-27-2023

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

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		Yes	No
1. Do you <u>currently</u> smoke tobacco, or have you smoked tobacco in the last month?	<input type="checkbox"/>	<input type="checkbox"/>	5. Do you <u>currently</u> have any of the following symptoms of pulmonary or lung illness?		
2. Have you <u>ever had</u> any of the following conditions?			a. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
a. Seizures	<input type="checkbox"/>	<input type="checkbox"/>	b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	<input type="checkbox"/>	<input type="checkbox"/>
b. Diabetes (sugar disease)	<input type="checkbox"/>	<input type="checkbox"/>	c. Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
c. Allergic reactions that interfere with your breathing	<input type="checkbox"/>	<input type="checkbox"/>	d. Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
d. Claustrophobia (fear of closed-in places)	<input type="checkbox"/>	<input type="checkbox"/>	e. Shortness of breath when washing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>
e. Trouble smelling odors	<input type="checkbox"/>	<input type="checkbox"/>	f. Shortness of breath that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
f. Heat stroke	<input type="checkbox"/>	<input type="checkbox"/>	g. Coughing that produces phlegm (thick sputum)	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you <u>ever had</u> any of the following pulmonary or lung problems?			h. Coughing that wakes you early in the morning	<input type="checkbox"/>	<input type="checkbox"/>
a. Asbestosis	<input type="checkbox"/>	<input type="checkbox"/>	i. Coughing that occurs mostly when you are lying down	<input type="checkbox"/>	<input type="checkbox"/>
b. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	j. Coughing up blood in the last month	<input type="checkbox"/>	<input type="checkbox"/>
c. Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	k. Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
d. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	l. Wheezing that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
e. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	m. Chest pain when you breathe deeply	<input type="checkbox"/>	<input type="checkbox"/>
f. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	n. Any other symptoms that you think may be related to lung problems	<input type="checkbox"/>	<input type="checkbox"/>
g. Silicosis	<input type="checkbox"/>	<input type="checkbox"/>	6. Have you <u>ever had</u> any of the following cardiovascular or heart symptoms?		
h. Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/>	a. Frequent pain or tightness in your chest	<input type="checkbox"/>	<input type="checkbox"/>
i. Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>	b. Pain or tightness in your chest during physical activity	<input type="checkbox"/>	<input type="checkbox"/>
j. Broken ribs	<input type="checkbox"/>	<input type="checkbox"/>	c. Pain or tightness in your chest that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
k. Any chest injuries or surgeries	<input type="checkbox"/>	<input type="checkbox"/>	d. In the past two years, have you noticed your heart skipping or missing a beat	<input type="checkbox"/>	<input type="checkbox"/>
l. Any other lung problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>			
4. Have you <u>ever had</u> any of the following cardiovascular or heart problems?					
a. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>			
b. Stroke	<input type="checkbox"/>	<input type="checkbox"/>			
c. Angina	<input type="checkbox"/>	<input type="checkbox"/>			
d. Heart failure	<input type="checkbox"/>	<input type="checkbox"/>			
e. Swelling in your legs or feet (not caused by walking)	<input type="checkbox"/>	<input type="checkbox"/>			
f. Heart arrhythmia (heart beating irregularly)	<input type="checkbox"/>	<input type="checkbox"/>			
g. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>			
h. Any other heart problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>			

Duke ID _____

Employee Name _____

- | | Yes | No |
|--|--------------------------|--------------------------|
| 6 e. Heartburn or indigestion that is not related to eating | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Any other symptoms that you think may be related to heart or circulation problems | <input type="checkbox"/> | <input type="checkbox"/> |

7. Do you currently take medication for any of the following problems?

- | | | |
|-------------------------------|--------------------------|--------------------------|
| a. Breathing or lung problems | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Heart trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Seizures | <input type="checkbox"/> | <input type="checkbox"/> |

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

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check no on this line and go to question 9)

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Eye irritation | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Skin allergies or rashes | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| d. General weakness or fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Any other problem that interferes with your use of a respirator | <input type="checkbox"/> | <input type="checkbox"/> |

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

- | | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|

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)?	<input type="checkbox"/>	<input type="checkbox"/>

11. Do you currently have any of the following vision problems?

- | | | |
|------------------------------------|--------------------------|--------------------------|
| a. Wear contact lenses | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Wear glasses | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Color blind | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Any other eye or vision problem | <input type="checkbox"/> | <input type="checkbox"/> |

12. Have you ever had an injury to your ears, including a broken ear drum?

- | | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|

13. Do you currently have any of the following hearing problems?

- | | | |
|-------------------------------------|--------------------------|--------------------------|
| a. Difficulty hearing | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Wear a hearing aid | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Any other hearing or ear problem | <input type="checkbox"/> | <input type="checkbox"/> |

14. Have you ever had a back injury?

- | | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|

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

15. Do you currently have any of the following musculoskeletal problems?

- | | Yes | No |
|---|--------------------------|--------------------------|
| a. Weakness in any of your arms, hands, legs, or feet | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Back pain | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Difficulty fully moving your arms and legs | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Pain or stiffness when you lean forward or backward at the waist | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Difficulty fully moving your head up or down | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Difficulty fully moving your head side to side | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Difficulty bending at your knees | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Difficulty squatting to the ground | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Climbing a flight of stairs or a ladder carrying more than 25 pounds | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Any other muscle or skeletal problem that interferes with using a respirator | <input type="checkbox"/> | <input type="checkbox"/> |