HCAVa
An HCA affiliate

Occupational Health

Chippenham • John Randolph
Parham Doctors' • Retreat Doctors'

OSHA Mandated Respiratory Questionnaire
Appendix C to 19 10.1 34 Effective 10198

☐ CJW Clinic ☐ RDH Clinic
☐ PDH Clinic ☐ JRMC Clinic

Name:_____ SSN:_____ Today's Date:_____
(Last, First, MI)

DOB:_____ Your Age:_____ Sex: ☐ M ☐ F Height:_____ft _____in Weight:_____lbs

Employer: _____

Phone Number:_____ (where you can be reached by the health professional who reviews this questionnaire)

Best time to call you at this number:_____

The Health Care Professional who will review this questionnaire:_____ Phone:_____

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

a._____ N, R, or P disposable respirator (filler-mask, non-cartridge type only)

b._____ Other type (for example: half- or full-facepiece type, powered-air purifying, and supplied air, SCBA)

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

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 problem 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.	Cough 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

Chippenham Hospital
7137 Jahnke Road
Richmond, Virginia 23225
Phone: 804-228-6708
Fax: 804-228-6709
Emergency: 804-323-8900

John Randolph Medical Center
411 West Randolph Road
Hopewell, Virginia 23860
Phone: 804-414-0312
Fax: 804-414-0313
Emergency Dept: 804-541-7505

Parham Doctors' Hospital
7700 East Parham Rd.
Richmond, Virginia 23294
Phone: 804-747-5627
Fax: 804-747-5702
Emergency: 804-747-5700

Retreat Doctors' Hospital
2621 Grove Avenue
Richmond, Virginia 23220
Phone: 804-254-5467
Fax: 804-254-9898
Emergency: 804-254-5433

Chippenham Hospital and Johnston-Willis Hospital are campuses of CJW Medical Center. Parham Doctors' Hospital and Retreat Doctors' Hospital are campuses of Henrico Doctors' Hospital.

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 (irregular heart beat) ..... 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 medications 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, 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 to this questionnaire?** ..... Yes No

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Questions 10-15 must be answered if you are going to use either a full-facepiece respirator or self-contained breathing apparatus (SCBA).

10. **Have you *ever lost* vision in either eye (temporarily or permanently)?** ..... Yes No

11. **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

12. **Have you *ever had* an injury to your ears, including a broken eardrum?** ..... Yes No

13. **Do you *currently* have any of the following problems?**
    a. Difficulty hearing ..... Yes No
    b. Any other hearing problems ..... Yes No
    c. Wear a hearing aid ..... Yes No

14. **Have you *ever had* a back injury?** ..... Yes No

15. **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 and 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. Difficulty 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

Signature of Employee: _____ Date: _____