Submit by Email

OSHA Respiratory Medical Evaluation Questionnaire Results

EMPLOYER INFORMATION

Employer Name: _____ **Phone Number:** _____

Employer Address: _____

Authorized Contact: _____ **Fax Number:** _____

EMPLOYEE INFORMATION

Employee Name: _____ **Phone Number:** _____

Employee Birthdate: _____ **Employee SSN#:** _____

FOR OFFICE USE ONLY

Examination Requested:

- ☐ Respirator Medical Questionnaire
- ☐ Respirator Use Physical Exam

Examination Findings:

- ☐ He\She must call and schedule an appointment for a physical before a decision can be made.
- ☐ He\She is MEDICALLY APPROVED to use a respirator.
- ☐ He\She is NOT medically approved to use a respirator.

_____ _____

Physicians Signature Date

Options for completing and submitting questionnaires:

1) Online via our website (www.primaryhealth.com)
2) Via fax to health care provider (208-344-7152)
3) Via email to health care provider (occmed@primaryhealth.com)
4) Via postal mail OR hand delivered in a sealed envelope to:

Primary Health Medical Group
Occupational Health Department
Attn: OSHA Respiratory Review
6052 W State St
Boise, ID 83703

Occupational Health Registration Form

Primary Health Medical Group

Patient Information:

Last Name: First Name: M.I.:

Mailing Address: Apt #:

City/State/Zip:

Home Phone: Cell Phone: Work Phone:

Preferred method of contact for reminder calls and other electronically generated messages:

(Please Select Only One Option) ☐ Voice ☐ Text

If Voice, Please Select Preferred Number :

☐ Home ☐ Cell ☐ Work

Date of Birth: Sex: Male Female Family Physician Name:

Marital Status: Social Security #:

Employer Information and Reason for Visit:

Employer Name: Employer Address: City/State/Zip:

Employer Phone: Employer Fax:

☐ Work Injury Care Date of Injury: _____ How did your injury occur?

☒ Other (describe) OSHA Respiratory Questionnaire

☐ Drug Screen *Test Type* ☐ Non-DOT ☐ DOT ☐ Observed

☐ Breath Alcohol *If DOT* ☐ FMCSA ☐ FTA ☐ FAA ☐ FRA ☐ USCG ☐ PHMSA ☐ HHS

Reason For Test ☐ Post Accident/Injury ☐ Pre-Emp ☐ Random ☐ Reasonable Suspicion ☐ Return to Duty/Follow-Up

Additional Information:

Emergency Contact: Phone: Relationship to Patient:

Race (please select): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline

Ethnicity (please select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Decline ☐ Other ☐ Sign Language ☐ Spanish ☐ Russian ☐ Indian (including Hindi & Tamil)

Can we leave a message regarding your medical care and test results? ☐ Yes ☐ No

Email Address: **Preferred Pharmacy/Location:**

I have read and agree to Primary Health Medical Group's (PHMG) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to PHMG all money to which I am entitled for medical expenses related to the services performed from time to time by PHMG, but not to exceed my indebtedness to PHMG. I authorize PHMG to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $15.00 returned check fee will be charged for checks returned due to insufficient funds. By choosing text messaging and/or email as a communication method, I acknowledge that Primary Health Medical Group is not liable for any wireless charges I may incur and that unencrypted patient information may be sent to me via text message or email. MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to PHMG. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. This office has chosen to participate in the Idaho Health Data Exchange (IHDE). If you do not wish to share your healthcare information with other medical providers you can contact the IHDE at (208)332-7253 or www.idahohde.org

Authorization to release to employer: By signing this form, you are hereby authorizing PHMG to release to your employer, information associated with any Occupational Health service. This may include, but is not limited to, information related to any pre-employment physical, fitness-for duty test, drug screening, or any other employer-ordered service unrelated to injury or illness.

Notwithstanding the foregoing, PHMG reserves the right to release any information to the employer without your authorization to the extent required or allowed by applicable law, including but not limited to disclosures for workers compensation, payment purposes, or other purposes identified in our Notice of Privacy Practices.

I have reviewed a copy of Primary Health Medical Group's Privacy Notice. ☐ **(Initials)**

Patient/Guardian Signature: _____ **Date:** _____

Patient/Guardian Printed Name:

FOR OFFICE USE ONLY **Check-In Time:**

WORKERS' COMPENSATION

W/C Surety: _____ Surety Phone: _____ Surety Fax: _____

Company Contact Name: _____ Title: _____ Phone Number: _____

Date/Time Contacted: _____ By: _____ **Secure Fax Number:** _____

Employer Screen Available for WC? ☐ Yes ☐ No (If No, send copy to OH) Notes: _____

DRUG AND ALCOHOL SCREENING - TRACKING INFORMATION

☐ Billed in eCW ☐ COC/ATF Faxed/Mailed to MRO/Employer

Staff: _____ Courier: _____ Tracking Number: _____ ☐ Pick-up Scheduled

OTHER SPECIAL SERVICES AUTHORIZED BY OH

☐ Billed in eCW ☐ Employer notified of results per employer screen

Staff: _____

Notes:

R 3/16

Code	Service	Price
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

OSHA Respirator Medical Evaluation Questionnaire

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

To the employee: Can you read (mark one box): ☐ 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 employer or supervisor must not look at or review you answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A Section 1. (Mandatory). ***The following information must be provided by every employee who has been selected to use any type of respirator (please print).***

1. Today's date: _____
2. Your name: _____
3. Your age (to nearest year): _____
4. Sex (mark one box): ☐ 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 the area code):_____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire (mark one box): ☐ Yes ☐ No
11. Check the type of respirator you will use (you can check more than one category):
    - ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
    - ☐ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator (mark one box): ☐ Yes ☐ No

    If yes, what type(s): _____

<u>Part A Section 2</u>. (Mandatory) ***Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please mark 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 (except when you had a cold): ☐ 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'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 an 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?
   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'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 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\circulation problems: ☐ Yes ☐ No

7. Do you **currently** take medication 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 that occurs only when you use the respirator: ☐ Yes ☐ No
   d. Unusual 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 on this questionnaire? ☐ Yes ☐ No

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

10. Have you **ever lost** vision is 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 hearing problems?
    a. Difficulty hearing: ☐ Yes ☐ No
    b. Wear a hearing aid: ☐ Yes ☐ No
    c. Any other hearing or ear problem: ☐ 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 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. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs: ☐ Yes ☐ No
    j. Any other muscle or skeletal problems that interferes with using a respirator: ☐ Yes ☐ No

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Part B. ***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.***

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're working under these conditions: ☐ Yes ☐ No

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: ☐ 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 (e.g. in sandblasting): ☐ Yes ☐ No
   c. Tungsten\cobalt (e.g. 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 (in training or combat): ☐ Yes ☐ No

8. Have you ever worked on a HAZMAT team: ☐ Yes ☐ No

9. Any other medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications currently 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) (mark yes or no for all answers that apply to you)?

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: ☐ Yes ☐ No

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 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 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 effort are: **lifting** a heavy load (about 50 lbs) from the floor to your waist or shoulder; **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 your respirator: ☐ Yes ☐ No

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

_____

14. Will you be working under hot conditions (temperature exceeding 77 degrees F)? ☐ Yes ☐ No

15. Will you be working under humid conditions? ☐ Yes ☐ No

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): _____

_____

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):
    a. Name of the first toxic substance: _____
       Estimated maximum exposure level per shift: _____
       Duration of exposure per shift: _____
    b. Name of the second toxic substance: _____
       Estimated maximum exposure level per shift: _____
       Duration of exposure per shift: _____
    c. Name of the third toxic substance: _____
       Estimated maximum exposure level per shift: _____
       Duration of exposure per shift: _____
    d. The name of any other toxic substances that you'll be exposed to while using your respirator:
       _____

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):

_____

_____