**Appendix B**

**Occupational Health Monitoring**



**If an employee has previously used or is recommended to use a respirator by health care provider this document must be reviewed and updated annually**

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

**To the employee:** Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. Once completed by Potential Animal Facility User, this form must be given to a primary care physician for review before your health clearance. This form should **not** be submitted to OSHA.

**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 (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 phone you at this number:
10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No
11. Check the type of respirator you will use (you can check more than one category):
    1. \_\_\_ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
    2. \_\_\_ 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 (circle one): Yes/No If “yes,” what type(s):



**Part A. Section 2. (Mandatory)** Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle “yes” or “no”).

**YES NO**

| 1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month? 2. Have you *ever had* any of the following conditions?    1. Seizures    2. Diabetes (sugar disease)    3. Allergic reactions that interfere with your breathing    4. Claustrophobia (fear of closed-in places)    5. Trouble smelling odors 3. Have you *ever had* 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 🞈 🞈

1. Do you *currently* have any of the following symptoms of pulmonary or lung illness? 🞈 🞈

a. Shortness of breath 🞈 🞈

* 1. Shortness of breath when walking fast on level ground or walking up a slight hill or 🞈 🞈

incline

* 1. Shortness of breath when walking with other people at an ordinary pace on 🞈 🞈

level ground

* 1. Have to stop for breath when walking at your own pace on level ground 🞈 🞈
  2. Shortness of breath when washing or dressing yourself 🞈 🞈
  3. Shortness of breath that interferes with your job 🞈 🞈
  4. Coughing that produces phlegm (thick sputum) 🞈 🞈
  5. Coughing that wakes you early in the morning 🞈 🞈
  6. Coughing that occurs mostly when you are lying down 🞈 🞈
  7. Coughing up blood in the last month 🞈 🞈
  8. Wheezing 🞈 🞈
  9. Wheezing that interferes with your job 🞈 🞈
  10. Chest pain when you breathe deeply 🞈 🞈
  11. Any other symptoms that you think may be related to lung problems 🞈 🞈

1. Have you *ever had* any of the following cardiovascular or heart problems? YES NO
   1. Heart attack 🞈 🞈
   2. Stroke 🞈 🞈
   3. Angina 🞈 🞈
   4. Heart failure 🞈 🞈
   5. Swelling in your legs or feet (not caused by walking) 🞈 🞈
   6. Heart arrhythmia (heart beating irregularly) 🞈 🞈
   7. High blood pressure 🞈 🞈
   8. Any other heart problem that you've been told about 🞈 🞈
2. Have you *ever had* any of the following cardiovascular or heart symptoms?
3. Frequent pain or tightness in your chest 🞈 🞈
4. Pain or tightness in your chest during physical activity 🞈 🞈
5. Pain or tightness in your chest that interferes with your job 🞈 🞈
6. In the past two years, have you noticed your heart skipping or missing a beat 🞈 🞈
7. Heartburn or indigestion that is not related to eating 🞈 🞈
8. Any other symptoms that you think may be related to heart or circulation problems 🞈 🞈
9. Do you *currently* take medication for any of the following problems?

a. Breathing or lung problems 🞈 🞈

* 1. Heart trouble 🞈 🞈
  2. Blood pressure 🞈 🞈
  3. Seizures 🞈 🞈

1. 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.)

* 1. Eye irritation 🞈 🞈
  2. Skin allergies or rashes 🞈 🞈
  3. Anxiety 🞈 🞈
  4. General weakness or fatigue 🞈 🞈
  5. Any other problem that interferes with your use of a respirator 🞈 🞈

1. Would you like to talk to the health care professional who will review this questionnaire 🞈 🞈

about your answers to this questionnaire?

**YES NO**

| 1. Have you *ever* lost vision in either eye (temporarily or permanently)? 2. Do you *currently* have any of the following vision problems?    1. Wear contact lenses    2. Wear glasses    3. Color blind    4. Any other eye or vision problem | 🞈  🞈  🞈  🞈  🞈 | 🞈  🞈  🞈  🞈  🞈 |
| --- | --- | --- |

1. Have you *ever had* an injury to your ears, including a broken eardrum? 🞈 🞈
2. Do you *currently* have any of the following hearing problems?

a. Difficulty hearing 🞈 🞈

* 1. Wear a hearing aid 🞈 🞈
  2. Any other hearing or ear problem 🞈 🞈

1. Have you *ever had* a back injury? 🞈 🞈
2. Do you *currently* have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet 🞈 🞈

* 1. Back pain 🞈 🞈
  2. Difficulty fully moving your arms and legs 🞈 🞈
  3. Pain and stiffness when you lean forward or backward at the waist 🞈 🞈
  4. Difficulty fully moving your head up or down 🞈 🞈
  5. Difficulty fully moving your head side to side 🞈 🞈
  6. Difficulty bending at your knees 🞈 🞈
  7. Difficulty squatting to the ground 🞈 🞈
  8. Climbing a flight of stairs or a ladder carrying more than 25 lbs. 🞈 🞈

Any other muscle or skeletal problem that interferes with using a respirator 🞈 🞈

List them \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part A: Section 3. Health Care Provider Recommendation This section must be completed by the healthcare provider reviewing the questionnaire**

**Indicate** whether respirator was previously used or currently recommended for use in an animal research facility

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Healthcare provider's name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Healthcare provider’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_