

# AMERICAN STEAMSHIP COMPANY LIBERTY STEAMSHIP COMPANY

Centerpointe Corporate Park  
500 Essjay Road  
Williamsville, NY 14221-8226

## Respiratory Medical Evaluation Questionnaire

ONLY for:  Wiper/Gatemen  
(check one)  Conveyor Men  
 Utility Maintenance Men

**Must Be Completed Using PEN! Pencil Not Accepted.**

Date \_\_\_\_\_

### Section 1

NAME _____	AGE _____	DATE of BIRTH _____	SEX: M F	Ht _____	Wt _____
ADDRESS _____			SS# _____		
JOB TITLE _____					
HOME PHONE _____		Best time to call _____		WORK PHONE _____	
Best time to call _____					
<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Has your employer told you how to contact the health care professional who reviews this questionnaire?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Have you worn a respirator?</b>					
<b>Check the type of respirator you will use (you can check more than one category):</b>					
<input type="checkbox"/> N,R,P disposable respirator (filter-mask, non-cartridge type only)					
<input type="checkbox"/> Other type (for example, half or full facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus)					
<b>How often are you expected to use a respirator? (check all that apply):</b>					
<input type="checkbox"/> Yes <input type="checkbox"/> No Escape only, no rescue		<input type="checkbox"/> Yes <input type="checkbox"/> No Less than 5 hours per week		<input type="checkbox"/> Yes <input type="checkbox"/> No Less than 2 hours per day	
<input type="checkbox"/> Yes <input type="checkbox"/> No Emergency rescue only		<input type="checkbox"/> Yes <input type="checkbox"/> No 2-4 hours per day			

### Section 2

<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Do you currently smoke?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Have you smoked a cigarette within the past hour?</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Have you ever smoked?</b> If yes, when did you last smoke?		<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Have you used a fast acting bronchodilator within the last 2 hours?</b>	
<b>Have you ever had the following conditions?</b>			
<input type="checkbox"/> Yes <input type="checkbox"/> No Seizures (fits)		<input type="checkbox"/> Yes <input type="checkbox"/> No Claustrophobia (fear of closed in places)	
<input type="checkbox"/> Yes <input type="checkbox"/> No Trouble smelling odors		<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes (sugar disease)	
		<input type="checkbox"/> Yes <input type="checkbox"/> No Allergic reactions that interfere with your breathing	
<b>Have you ever had any of the following pulmonary or lung problems?</b>			
<input type="checkbox"/> Yes <input type="checkbox"/> No Asbestosis		<input type="checkbox"/> Yes <input type="checkbox"/> No Silicosis	
<input type="checkbox"/> Yes <input type="checkbox"/> No Asthma		<input type="checkbox"/> Yes <input type="checkbox"/> No Lung cancer	
<input type="checkbox"/> Yes <input type="checkbox"/> No Chronic bronchitis		<input type="checkbox"/> Yes <input type="checkbox"/> No Pneumonia	
4 <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema		<input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis	
		<input type="checkbox"/> Yes <input type="checkbox"/> No Broken ribs	
		<input type="checkbox"/> Yes <input type="checkbox"/> No Chest injuries or surgeries	
		<input type="checkbox"/> Yes <input type="checkbox"/> No Pneumothorax (collapsed lung)	
		<input type="checkbox"/> Yes <input type="checkbox"/> No Any lung problem you've been told about	
<b>Do you currently have any of the following symptoms of pulmonary or lung illness?</b>			
<input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath		<input type="checkbox"/> Yes <input type="checkbox"/> No Coughing that produces phlegm (thick sputum)	
<input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath when walking fast on level ground or walking up a slight hill or incline		<input type="checkbox"/> Yes <input type="checkbox"/> No Coughing that wakes you early in the morning	
<input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath when walking with other people at an ordinary pace on level ground		<input type="checkbox"/> Yes <input type="checkbox"/> No Coughing that occurs mostly when you are lying down	
<input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had to stop for breath when walking at pace on level ground		<input type="checkbox"/> Yes <input type="checkbox"/> No Coughing up blood in the past month	
<input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath when washing or dressing yourself		<input type="checkbox"/> Yes <input type="checkbox"/> No Wheezing	
<input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath that interferes with your job		<input type="checkbox"/> Yes <input type="checkbox"/> No Wheezing that interferes with your job	
		<input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain when you breathe deeply	
		<input type="checkbox"/> Yes <input type="checkbox"/> No Any other symptoms that you think may be related to lung problems (If Yes, list)	

**Section 2 continued**

<b>Have you ever had any of the following cardiovascular or heart problems?</b>					
<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling in your legs or feet, not caused by walking
<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart arrhythmia (heart beating irregularly)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Angina			<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other heart problem that you have been told about
<b>Have you ever had any of the following cardiovascular or heart symptoms?</b>					
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain or tightness in your chest that interferes with your job	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heartburn or indigestion that is not related to eating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other symptoms that you think may be related to heart or circulation problems
<input type="checkbox"/> Yes <input type="checkbox"/> No	In the past 2 years, have you noticed your heart skipping or missing a beat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent pain or tightness in your chest		
<b>Do you currently take medications for any of the following problems?</b>					
<input type="checkbox"/> Yes <input type="checkbox"/> No	Breathing or lung problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures (fits)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart				
<b>If you have used a respirator, have you ever had any of the following problems?</b>					
<input type="checkbox"/> Check here if you have <i>never used a respirator</i> and proceed to <b>Section 3</b>					
<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye irritation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other problem that interferes with your use of a respirator?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin allergies or rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No	General weakness or fatigue		

**Section 3:**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>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?</b>				
<b>Have you ever worked with any of the materials, or under any of the following conditions:</b>					
<input type="checkbox"/> Yes <input type="checkbox"/> No	Asbestos	<input type="checkbox"/> Yes <input type="checkbox"/> No	Aluminum	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tungsten/cobalt (grinding or welding this material)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Tin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dusty environments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other hazardous exposures. If yes, describe:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Iron	<input type="checkbox"/> Yes <input type="checkbox"/> No	Coal (such as mining)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Beryllium	<input type="checkbox"/> Yes <input type="checkbox"/> No	Silica (used in sandblasting)		
<b>List any second jobs or side businesses you have:</b>					
<b>List your previous occupations:</b>					
<b>List your current and previous hobbies:</b>					
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over the counter medications)?</b>				
<b>Will you be using any of the following items with your respirator(s)?</b>					
<input type="checkbox"/> Yes <input type="checkbox"/> No	HEPA Filters	<input type="checkbox"/> Yes <input type="checkbox"/> No	Canisters (for example, gas masks)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cartridges

\_\_\_\_\_ Employee Signature

\_\_\_\_\_ Date

<b>St. Luke's Occupational Health Use Only.</b>	Reviewed by: _____	Date: _____
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