Bridgestone Aiken PSR

Respirator and Surveillance Evaluation History

TEAMMATE'S SIGNATURE			DATE	
SOCIAL SECURITY NO:			DATE	
TEAMMATE'S NAME			COMPANY	LOCATION
TEAMMATE'S STREET ADDRESS			DEPARTMENT	JOB TITLE
CITY, STATE		ZIP CODE	EMERGENCY CONTACT NAME, RELATION AND PHONE	
AGE	SEX	HEIGHT	WEI GHT	PHONE NUMBER AND A GOOD TIME TO REACH YOU

The following questionnaire is required by the Occupational Safety and Health Administration (OSHA) for Respirator users. This is also used in other teammate health examinations. Please answer all questions accurately. If you do not have an actual physician examination, your facility representative will let you know how to contact the health professional who will be reviewing this questionnaire.

(1) Can you read? Y N If NO, person assisting with questionnaire:

(1A) Do you currently smoke? Circle all that apply: cigarettes cigars pipe **Y N**
Age when you started:

(2) CONDITIONS Have you ever had (circle):

Seizures, fits or epilepsy	Y N (a)	Allergic reactions interfering with breathing	Y N (c)
Diabetes or sugar	Y N (b)	Claustrophobia (fear of closed-in spaces)	Y N (d)

Please provide details on all YES responses:

(3) PULMONARY OR LUNG PROBLEMS Have you had

Asbestosis	Y N (a)	Silicosis	Y N (g)
Asthma	Y N (b)	Pneumothorax (collapsed lung)	Y N (h)
Chronic bronchitis	Y N (c)	Lung cancer	Y N (i)
Emphysema	Y N (d)	Broken ribs	Y N (j)
Pneumonia	Y N (e)	Other chest injuries or surgeries	Y N (k)
Tuberculosis	Y N (f)	Any other lung or breathing problem (list)	Y N (l)

Please provide details on all YES responses:

(4) PULMONARY OR LUNG SYMPTOMS Do you have

Shortness of breath	Y N (a)	Coughing that wakes you early in the morning	Y N (h)
Shortness of breath when walking fast on level ground or up a slight hill or incline	Y N (b)	Coughing that occurs when you are lying down	Y N (i)
Shortness of breath when walking with other people at a normal pace on level ground	Y N (c)	Coughing up blood in the last month	Y N (j)
To stop to catch your breath when walking at your own pace on level ground	Y N (d)	Wheezing	Y N (k)
Shortness of breath when washing or dressing yourself	Y N (e)	Wheezing that interferes with your job	Y N (l)
Shortness of breath that interferes with your job	Y N (f)	Chest pain when you breath deeply	Y N (m)
Coughing that produces phlegm (thick sputum)	Y N (g)	Other symptoms related to your lungs or breathing	Y N (n)

Please provide details on all YES responses:

(5) CARDIOVASCULAR OR HEART PROBLEMS Have you ever had (circle)

Heart attack	Y N (a)	Swelling of your legs or feet (not caused by standing)	Y N (e)
Stroke	Y N (b)	Heart arrhythmia (irregular heart beats)	Y N (f)
Angina	Y N (c)	High blood pressure	Y N (g)
Heart failure	Y N (d)	Any other heart or circulation problem	Y N (h)

Please provide details on all YES responses:

Bridgestone Aiken PSR

Respirator and Surveillance Evaluation History

(6) CARDIOVASCULAR OR HEART SYMPTOMS Have you ever had			
Frequent pain or tightness in your chest	Y N (a)	Heart beating irregularly or skipping beats in the past 2 years	Y N (d)
Pain or tightness in your chest during physical activity	Y N (b)	Heartburn or indigestion that is NOT related to eating	Y N (e)
Chest pain or tightness that interferes with your job	Y N (c)	Other symptoms related to your heart or circulation	Y N (f)

Please provide details on all YES responses:

(7) MEDICATIONS Do you currently take medicines for the following:			
Breathing or lung problems (including inhalers)	Y N (a)	High blood pressure	Y N (c)
Heart problems	Y N (b)	Seizures (fits)	Y N (d)

List other medications and allergies below.

(8) PROBLEMS WITH RESPIRATOR USE Have you ever had:			
Eye irritation from a respirator	Y N (a)	Weakness or fatigue using a respirator	Y N (d)
Skin allergies or reactions to a respirator	Y N (b)	Any other problem interfering with use of a respirator	Y N (e)
Anxiety or fear wearing a respirator	Y N (c)		Y N (f)

Please provide details on all YES responses:

(9) Have you ever lost vision either eye (temporary or permanent)?	**Y N**

Please provide details on all YES responses:

(10) VISION PROBLEMS Do you currently:			
Wear contact lenses	Y N (a)	Know you are color blind	Y N (c)
Wear glasses	Y N (b)	Have any other eye or vision problems	Y N (d)

Please provide details on all YES responses:

(11) Have you ever had an EAR injury or broken ear drum?	**Y N**

Please provide details on all YES responses:

(12) HEARING PROBLEMS Do you currently:			
Have difficulty hearing	Y N (a)	Have any other ear or hearing problems	Y N (c)
Wear a hearing aid	Y N (b)		

Please provide details on all YES responses:

Bridgestone Aiken PSR

Respirator and Surveillance Evaluation History

(13) Have you ever had a BACK injury? **Y N**

Please provide details on all YES responses:

(14) MUSCULOSKELETAL PROBLEMS Do you currently have:

Weakness in arms, hands, legs, feet	Y N (a)	Difficulty fully moving your head side to side	Y N (f)
Back pain	Y N (b)	Difficulty bending your knees	Y N (g)
Difficulty moving your arms or legs	Y N (c)	Difficulty squatting to the ground?	Y N (h)
Pain or stiffness when bending forward or backward	Y N (d)	Difficulty climbing a flight of stairs or ladder carrying more than 25 pounds	Y N (i)
Difficulty fully moving your head up and down	Y N (e)	Other muscle or bone problem that interferes with respirator use	Y N (j)

Please provide details on all YES responses:

(15) PAST WORK AND EXPOSURE HISTORY Have you ever worked with:

Asbestos	Y N (a)	Aluminum	Y N (e)
Silica, mining, or sandblasting	Y N (b)	Coal (mining)	Y N (f)
Tungsten or cobalt (grinding or welding)	Y N (c)	Iron or Tin	Y N (g)
d.) Beryllium	Y N (d)	Other dusty environments	Y N (h)

Please provide details on all YES responses:

(16) Would you like to speak with the health professional who will review this questionnaire? **Y N**

Please provide information or questions for the health professional:

----------DO NOT WRITE BELOW THIS LINE----------

REVEW BY HEALTH PROFESSIONAL COMPLETE THIS IF THERE IS NO PHYSICAL EXAM

Need for Medical examination or referral? **Y N**

Provide dates and details of phone calls or other review activities:

Reviewer: _____ **Signature of Reviewer** _____