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AUDIOMETRIC HISTORY/HISTORIA AUDIOMETRICA

THIS INFORMATION AND THE HEARING RESULTS WILL BE SHARED WITH YOUR EMPLOYER

EMPLOYEE ID: _____

Last Name_____**First Name** _____**MI**_____
(Apellido) (Nombre) (Inicial del segundo nombre)

Date of Birth _____**Date of Hire**_____ **Sex**_____
(Fecha de nacimiento: mes/día/año) (Fecha de contrato) (Sexo)

Department _____ **Location** _____**Employee ID #** _____
(Departamento) (Area de la compañía) (Número de Empleo)

English					Spanish/Español				
	Yes	**No**		**Hrs**		**Sí**	**No**		**Horas**
I was exposed to loud noise today			How Long?		Yo estuve expuesto a ruido alto hoy			¿Cuánto tiempo?	

QUESTION	**Yes**	**No**	**Comments**	**PREGUNTA**	**Sí**	**No**	**Comentarios**
Ear pain				Dolor del oído			
Ear Drainage				Drenaje de fluido en el oído			
Dizziness/Imbalance				Mareo/Desequilibrio			
Ringing in ears				Zumbidos en los oídos			
Sudden hearing loss				Pérdida repentina de la audición			
Hearing loss (comes and goes)				El oído se va (de vez en cuando)			
Fullness Discomfort in ears				Sensación de oídos tapados			
Ear problems from ear muffs				Dolor de oído por los tapones			
Wax/object in ear canal				Cera/Objetos en el oído			
Wear hearing protection today				**¿Usó tapones en los oídos hoy?**			
Seen Dr. for ear problems				¿Ha visto un médico por problemas del oído?			
Ear, Head, Neck surgery				¿Ha tenido cirugía del oído, cabeza o cuello?			
Unconsciousness/head injury				Herida severa en la cabeza			
Have prescription hearing aid				¿Usa aparatos para oír mejor?			
Mumps				Paperas			
Scarlet Fever				Fiebre Escarlatina			
Head cold today				¿Tiene resfriado de cabeza hoy?			
Military Service				¿Estaba en el servicio militar?			
Noisy hobbies				Pasatiempos ruidosos			
Loud music/headphone use				Música fuerte/uso de auriculares			
Previous job with loud noise				Trabajo anterior era ruidoso			
Use firearms				¿Usa armas de fuego?			

Employee Signature/Firma **Date**

BY LAW THE FOLLOWING INFORMATION MUST BE PROVIDED BY ANYONE SELECTED TO USE A RESPIRATOR. **YOUR EMPLOYER MUST ALLOW YOU TO ANSWER THE 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 YOUR ANSWERS, AND YOUR EMPLOYER MUST TELL YOU HOW TO DELIVER OR SEND THIS QUESTIONNAIRE TO THE HEALTH CARE PROFESSIONAL WHO WILL REVIEW IT.**

--LEGIBLE PRINT ONLY PLEASE--

Part A. Section 1. (Mandatory)

L. Name F. Name Today's date / /

EMPLOYEE ID NUMBER _____

Race/Ethnicity Height (ft./in.) Weight (lbs.)

Gender/Sex Department Date of Birth / /

Have you ever worn a respirator: Y / N If yes what type:

Do you use a N, R, or P disposable type respirator (filter-mask, non-cartridge)? ☐ Yes ☐ No
Do you use a full or half mask, air purifying, air supplied, or self-contained breathing apparatus (SCBA) respirator? ☐ Yes ☐ No
Do you regularly use medication to help you breathe (ex., inhaler, etc.)? ☐ Yes ☐ No
Are you wearing dentures? ☐ Yes ☐ No
Approx. how much does your respirator weigh? _____
How often do you use a respirator: ☐ **Daily** ☐ **Weekly** ☐ **Monthly** ☐ **Other / explain:** _____
How long do you wear a respirator each time: ☐ 1-2 hrs. ☐ 2-4 hrs. ☐ 4-6 hrs. ☐ 6-8 hrs. ☐ Other:_____
Using a respirator, describe your physical activity ☐ Light ☐ Medium ☐ Heavy ☐ Other _____
Do you use any protective clothing with your respirator? ☐ Yes ☐ No If yes explain _____
Do you work under extreme temperatures or humidity? ☐ Yes ☐ No If yes explain _____

Part A. Section 2. (Mandatory)

1. Do you smoke tobacco or have you smoked tobacco in the last month? Yes / No
2. Have you had any of the following conditions:
   a. Seizures (fits) Yes / No
   b. Diabetes (sugar disease) Yes / No
   c. Allergic reaction that interfere with your breathing Yes / No
   d. Claustrophobia (fear of closed in spaces) 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 lung problems 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 a slight incline Yes / No
   c. Shortness of breath when walking 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 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

PLEASE COMPLETE BACK SIDE AND SIGN

FOR OFFICE USE ONLY

BLOOD PRESSURE / / Tech Init's
Comments
PROTEIN_____ GLUCOSE_____ KETONE_____ BLOOD_____

Med Compass, 7841 Wayzata Blvd., Suite 214, Minneapolis MN 55426, 952-542-9333, 800-205-8729

Part A. Section 2. PAGE 2

5. In the last 6 months 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 problems you've been told about	Yes / No

6. Have you 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 symptoms that you think may be related to heart or 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 had any of the following problems:
(If you've never used a respirator skip this section 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 problems that interferes with your use of respirator:	Yes / No

9. Have you ever lost vision in either eye (temporarily or permanently?:

10. Do you currently have any of the following vision problems:

		Yes / No
a.	Wear contact lenses	Yes / No
b.	Wear glasses	Yes / No
c.	Color blind	Yes / No
d.	Any other eye or vision problem	

11. Have you ever had an injury to your ears, including a broken ear drum? Yes / No

12. Do you currently have any of the following hearing problems:

		Yes / No
a.	Difficulty hearing	Yes / No
b.	Wear a hearing aid	Yes / No
c.	Any other hearing or ear problem	Yes / No

13. Have you ever had a back injury?

14. 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 moving your arms and legs	Yes / No
d.	Pain or stiffness when you lean forward or backward at the waist	Yes / No
e.	Difficulty moving your head up and down	Yes / No
f.	Difficulty 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.	Climbing a flight of stairs or a ladder carrying more than 25 lb.	Yes / No
j.	Any other muscle or skeletal problem that interferes with using a respirator	Yes / No

(This form complies with OSHA 1910.134, Respiratory Medical Evaluation Questionnaire.)

When finished filling out this form, please hand deliver it to the Med Compass Health Care Professional. If you have any questions about this form please contact Med Compass at (952) 542-9333 or 1-800-205-8729.

_____

(Employee Signature)

OSHA regulation 1910.134 concerning facial hair when wearing a respirator.
Facial hair is allowed as long as it does not "break the seal of the respirator on the face".

QUALITATIVE FIT TESTING QUESTIONNAIRE

EMPLOYEE DEMOGRAPHICS

EMPLOYEE NAME: _____

COMPANY/DEPARTMENT: _____

JOB DESCRIPTION: _____

RESPIRATOR USE HISTORY

QUESTIONS	YES	NO	COMMENTS
How often do you wear a respirator at work?	N/A		_____
How many hours do you typically wear a respirator in a day?.....	N/A		_____
Do you sanitize your respirator? If so how often?	☐	☐	_____
Do you inspect your respirator for defects? If so how often?.....	☐	☐	_____
Do you have an impaired or nonexistence sense of smell?	☐	☐	_____
Do you have an impaired or nonexistence sense of taste?	☐	☐	_____
Do you use eyewear while using a respirator? (If no skip next question)	☐	☐	_____
Does your eyewear interfere with your respirator? If so explain.....	☐	☐	_____
Do you have facial hair? (If no skip next question).....	☐	☐	_____

If you have facial circle which type

1) BEARD **2) MUSTACHE** **3) GOATEE**
4) WHISKERS **5) SIDE BURNS**

NOTE: The Respirator Fit Testing performed by Med Compass will only approve your use of the respirator/mask listed below. OSHA 1910.134 states that Respirator Fit Testing is an annual requirement.

_____ _____
EMPLOYEE SIGNATURE **DATE**

DO NOT WRITE BELOW THIS POINT - TECHNICIAN USE ONLY

TESTING SUBSTANCE:

1) BITREX **2) SACCHARIN**

RESPIRATOR USED (BRAND)	SIZE	PASS	FAIL	NOT TESTED	REASON

LEGEND: S=Small, M=Medium, L=Large, XL=X-Large, O=One Size Fits All
If "FAIL" – Give Reason / If "NOT TESTED" Give Reason

Technician Notes:

TEST ADMINISTRATOR: **DATE:**