Student Entrance Questionnaire
Auto Collision Repair & Refinish Technician Program

OSHA Respirator Medical Evaluation Questionnaire (Mandatory) Appendix C to Sec. 1910 . 134:

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

Dear Auto Collision Student:
Required respirator usage in the painting semester is covered by OSHA guidelines. Students with respiratory challenges may require a physician medical evaluation. Please complete the following questionnaire.

Can you read (check one): ☐ Yes ☐ No

To maintain your confidentiality, the college must not look at or review your answers, and will deliver this questionnaire to the college health nurse who will review it. You may discuss this questionnaire with the college health nurse at 1.888.468.6582 ext 1111.

Part A. Section 1. (Mandatory) The following information must be provided by every student who is participating in the Auto Collision Repair & Refinish Technician Program (please print).

1. Today's date: _____
2. Your name: _____
3. Your age (to nearest year): _____
4. Sex (check 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 college health nurse who reviews this questionnaire (include the Area Code): _____
9. The best time to phone you at this number: _____
10. Has the college told you how to contact the college health nurse who will review this questionnaire (check one): ☐ Yes ☐ No
11. Check the type of respirator you will use (you can check more than one category):
    a. ___X__ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
    b. ___X__ 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 (check one): ☐ Yes ☐ No

    If "yes," what type(s): _____

_____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every student who is participating in the Auto Collision Repair & Refinish Technician Program (please check "yes' or "no').

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month: (check one): ☐ 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: ☐ 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 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: ꕥ Yes ꕥ No
    b. Stroke: ꕥ Yes ꕥ No
    c. Angina: ꕥ Yes ꕥ No
    d. Heart failure: ꕥ Yes ꕥ No
    e. Swelling in your legs or feet (not caused by walking): ꕥ Yes ꕥ No
    f. Heart arrhythmia (heart beating irregularly): ꕥ Yes ꕥ No
    g. High blood pressure: ꕥ Yes ꕥ No
    h. Any other heart problem that you've been told about: ꕥ Yes ꕥ No

6. Have you ever had any of the following cardiovascular or heart symptoms?
    a. Frequent pain or tightness in your chest: ꕥ Yes ꕥ No
    b. Pain or tightness in your chest during physical activity: ꕥ Yes ꕥ No
    c. Pain or tightness in your chest that interferes with your job: ꕥ Yes ꕥ No
    d. In the past two years, have you noticed your heart skipping or missing a beat: ꕥ Yes ꕥ No
    e. Heartburn or indigestion that is not related to eating: ꕥ Yes ꕥ No
    f. Any other symptoms that you think may be related to heart or circulation problems: ꕥ Yes ꕥ No

7. Do you currently take medication for any or the following problems?
    a. Breathing or lung problems: ꕥ Yes ꕥ No
    b. Heart trouble: ꕥ Yes ꕥ No
    c. Blood pressure: ꕥ Yes ꕥ No
    d. Seizures (fits): ꕥ Yes ꕥ 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: ꕥ Yes ꕥ No
    b. Skin allergies or rashes: ꕥ Yes ꕥ No
    c. Anxiety: ꕥ Yes ꕥ No
    d. General weakness or fatigue: ꕥ Yes ꕥ No
    e. Any other problem that interferes with your use of a respirator: ꕥ Yes ꕥ No

9. Would you like to talk to the college health nurse who will review this questionnaire about your answers to this questionnaire?
    ꕥ Yes ꕥ No