

**OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (MANDATORY)**

**EMPLOYEE: Can you read (circle one): YES NO**

Your employer must allow you to answer this 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.

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**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).**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Work Area: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Phone number where you can be reached to answer questions by the health care professional who reviews this questionnaire. (Include area code): \_\_\_\_\_

The best time to call you at this number (normal working hours): \_\_\_\_\_

Has your employer told you how to contact the health care professional who will review this questionnaire?

Yes  No

Check type of respirator you will use (you may check more than one category)

Dust Mask (N, R, or P disposable respirator filter - mask, non cartridge type)

Half -- or full-face piece type  Power-air purifying  Supplied air

Hood/Helmet  Escape

SCBA/air tank  Non-powered cartridge or canister

Disposable  Non-Disposable  Other \_\_\_\_\_

Have you worn a respirator before?  Yes  No If "yes", what type(s): \_\_\_\_\_

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**At the end of each section you will find space to document additional information regarding any "YES" answers. Please include dates, physician's name, follow-up care, and indicate if this is an ongoing problem or if you have had surgery. If you need more space use the back of page 3.**

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**Part A. Section 2. General Health Information (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" where appropriate and provide additional information as needed).**

1. Yes No Do you **currently** smoke tobacco, or have you **smoked tobacco in the last month?**

If yes answer the following:

Yes No Cigarettes? Age started \_\_\_\_\_ Age quit \_\_\_\_\_ Number of packs/day smoked \_\_\_\_\_

Yes No Cigars? Age started \_\_\_\_\_ Age quit \_\_\_\_\_ Number of cigars/day smoked \_\_\_\_\_

Yes No Pipe? Age started \_\_\_\_\_ Age quit \_\_\_\_\_ Number of pipe bowls/day smoked \_\_\_\_\_

Yes No Did you inhale the smoke?

Yes No Chewing Tobacco? Number of cans used daily: \_\_\_\_\_

2. Have you **ever had** any of the following conditions:

Yes No Diabetes ( Insulin  Pills  Diet)

Yes No Seizures

Yes No Trouble smelling odors

Yes No Claustrophobia (fear of closed-in places)

Yes No Allergic reactions that interfere with your breathing

**Explain all YES answers**

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3. Have you **ever had** any of the following pulmonary or lung problems?

Yes No Asbestosis

Yes No Asthma

Yes No Emphysema

Yes No Pneumonia

Yes No Silicosis

Yes No Lung cancer

Yes No Chronic bronchitis

Yes No Broken ribs

Yes No Pneumothorax (collapsed lung)

Yes No Tuberculosis

Yes No Any chest injuries or surgeries

Yes No Any other lung problem that you've been told about?

**Explain all YES answers**

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

Yes No Shortness of breath

Yes No Shortness of breath when walking fast on level ground, or walking up a slight hill or incline

Yes No Shortness of breath when walking with other people at an ordinary pace on level ground

Yes No Have to stop to breath when walking at your own pace on level ground

Yes No Shortness of breath when washing or dressing yourself

Yes No Shortness of breath that interferes with your job

Yes No Coughing that produces phlegm (thick sputum)

Yes No Coughing that wakes you in early morning

Yes No Coughing that occurs mostly when you are lying down

Yes No Coughing up blood in the last month

Yes No Wheezing

Yes No Wheezing that interferes with your job

Yes No Chest pain when you breathe deeply

Yes No Any other symptoms that you think may be related to lung problems.

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5. Have you **ever had** any of the following cardiovascular or heart problems?

Yes No Heart attack

Yes No High blood pressure

Yes No Stroke

Yes No Swelling in your legs or feet (not caused by walking)

Yes No Heart arrhythmia (irregular heart beat)

Yes No Heart failure

Yes No Any other heart problem that you have been told about

Yes No Angina

**Explain all YES answers**

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6. Have you **ever had** any of the following cardiovascular or heart symptoms?

Yes No Frequent pain or tightness in your chest

Yes No Pain or tightness in your chest during physical activity

Yes No Pain or tightness in your chest that interferes with your job

Yes No In the past two years, have you noticed your heart skipping or missing a beat

Yes No Heart burn or indigestion that is not related to eating

Yes No Any other symptoms that you think may be related to heart or circulation problems

**Explain all YES answers**

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7. Do you **currently** take medications for any of the following problems?

Yes No Breathing/lung problem

Yes No Seizures

Yes No Heart trouble

Yes No Blood pressure

**Explain all YES answers**

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8. **If you have used a respirator**, have you **ever had** any of the following problems?

(If you have **never** used a respirator, check the following space and go to question 9: \_\_\_\_\_)

Yes No Eye irritation

Yes No Anxiety

Yes No Skin allergies or rashes

Yes No General weakness or fatigue

Yes No Any other problem that interferes with your use of a respirator

**Explain all YES answers**

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9. Yes No **Would you like to talk to the health care professional who will review your answers on the questionnaire?**

**Explain if answered YES**

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Questions 10 and 11 below must be answered by every employee who has been selected to use either a full face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Do you **currently** have any of the following eye or ear problems?
- Yes No Wear glasses
  - Yes No Wear contact lenses
  - Yes No Color blind
  - Yes No Have you ever lost vision in either eye (temporary or permanent)
  - Yes No If answered yes above, has the problem been corrected?  Yes  No
  - Yes No Any other eye or vision problem
  - Yes No Wear a hearing aid
  - Yes No Difficulty hearing
  - Yes No Any other hearing problems
  - Yes No Have you ever had an injury to your ears including broken ear drum?

**Explain all YES answers**

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11. Do you **currently** have any of the following musculoskeletal problems?
- Yes No Weakness in any of your arms, hands, legs or feet
  - Yes No Have you ever had a back injury
  - Yes No Back pain
  - Yes No Difficulty in moving your arms and/or legs
  - Yes No Pain or stiffness when you lean forward or backward at the waist
  - Yes No Difficult fully moving your head up or down
  - Yes No Difficulty fully moving your head side to side
  - Yes No Difficulty bending at your knees
  - Yes No Difficulty squatting to the ground
  - Yes No Difficulty climbing a flight of stairs or ladder carrying more than 25 lbs
  - Yes No Any other muscle or skeletal problem that interferes with using a respirator?

**Explain all YES answers**

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Signature of Employee

Date

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Signature of Physician

Date