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.

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): _____

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.

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

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

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.

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

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

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

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

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

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

_____

_____

_____

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

_____

_____

_____

_____ _____

Signature of Employee **Date** **Signature of Physician** **Date**