

Date _____

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

PART A SECTION 1

Can you read? **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.

The following information must be provided by every employee who has been selected to use any type of respirator (please print).

NAME: _____

AGE: _____ SEX: M / F _____ HEIGHT: _____ WEIGHT: _____

JOB TITLE: _____

Phone number where you can be reached by the health care professional who reviews this questionnaire:

Area code + number

The best time to reach you at this number: _____

Has your employer told you how to contact the health care professional who will review this questionnaire? **YES** **NO**

Check the type of respirator you will use (check all that apply):

_____ N, R, or P disposable respirator (filter-mask, non-cartridge type only)

_____ Other type (i.e., half- or full-facepiece type, powdered-air purifying, supplied-air, self-contained breathing apparatus)

PART A SECTION 2

Questions 1-9 must be answered by every employee who has been selected to use any type of respirator.

- | | | | |
|----|--|------------|-----------|
| 1. | Do you <i>currently</i> smoke tobacco, or have you smoked tobacco in the last month? | YES | NO |
| 2. | Have you <i>ever had</i> any of the following conditions? | | |
| | - Seizures (fits) | YES | NO |
| | - Diabetes (sugar disease) | YES | NO |
| | - Allergic reactions that interfere with your breathing | YES | NO |
| | - Claustrophobia (fear of closed-in places) | YES | NO |
| | - Trouble smelling odors | YES | NO |
| 3. | Have you <i>ever had</i> any of the following pulmonary or lung problems? | | |
| | - Asbestosis | YES | NO |
| | - Asthma | YES | NO |
| | - Chronic bronchitis | YES | NO |
| | - Emphysema | YES | NO |
| | - Pneumonia | YES | NO |
| | - Tuberculosis | YES | NO |
| | - Silicosis | YES | NO |
| | - Pneumothorax (collapsed lung) | YES | NO |
| | - Lung cancer | YES | NO |
| | - Broken ribs | YES | NO |
| | - Any chest injuries or surgeries | YES | NO |
| | - Any other lung problem that you have been told about | YES | NO |
| 4. | Do you <i>currently</i> have any of the following symptoms of pulmonary or lung illness? | | |
| | - 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 for 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 early in the 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 | YES | NO |
| 5. | Have you <i>ever had</i> any other of the following cardiovascular or heart problems? | | |
| | - Heart attack | YES | NO |
| | - Stroke | YES | NO |
| | - Angina | YES | NO |
| | - Heart failure | YES | NO |
| | - Swelling in your legs or feet (not caused by walking) | YES | NO |
| | - Heart arrhythmia (heart beating irregularly) | YES | NO |
| | - High blood pressure | YES | NO |
| | - Any other heart problem that you've been told about | YES | NO |

CONTINUED ON NEXT PAGE→

6. Have you *ever had* any of the following cardiovascular or heart symptoms?
- Frequent pain or tightness in your chest YES NO
 - Pain/tightness in your chest during physical activity YES NO
 - Pain/tightness in your chest that interferes with your job YES NO
 - In the past 2 years, have you noticed your heart skipping or missing a beat YES NO
 - Heartburn or indigestion that is not related to eating YES NO
 - Any other symptom 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?
- Breathing or lung problems YES NO
 - Heart trouble YES NO
 - Blood pressure YES NO
 - Seizures (fits) YES NO
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.)
- NEVER USED A RESPIRATOR PREVIOUSLY**
- Eye irritation YES NO
 - Skin allergies or rashes YES NO
 - Anxiety YES NO
 - General weakness or fatigue YES NO
 - Difficulty breathing YES NO
 - Chest pain YES NO
 - Any other problem that interferes with your use of a respirator YES NO
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? YES NO
10. Have you *ever* lost vision in either eye (temporarily or permanently) YES NO
11. Do you *currently* have any of the following vision problems?
- Wear contact lenses YES NO
 - Wear glasses YES NO
 - Color blind YES NO
 - Any other eye or vision problem YES NO
12. Have you *ever* had an injury to your ears, including a broken ear drum? YES NO
13. Do you *currently* have any of the following hearing problems?
- Difficulty hearing YES NO
 - Wear a hearing aid YES NO
 - Any other hearing or ear problem YES NO
14. Have you *ever* had a back injury YES NO

CONTINUED ON NEXT PAGE→

15. Do you *currently* have any of the following musculoskeletal problems?

- | | | |
|--|------------|-----------|
| - Weakness in any of your arms or hands or legs or feet | YES | NO |
| - Back pain | YES | NO |
| - Difficulty fully moving your arms/legs | YES | NO |
| - Pain/stiffness when you lean forward/backward at the waist | YES | NO |
| - Difficulty fully moving your head up/down | YES | NO |
| - Difficulty fully moving your head side/side | YES | NO |
| - Difficulty bending at your knees | YES | NO |
| - Difficulty squatting to the ground | YES | NO |
| - Climbing a flight of stairs or a ladder carrying more than 25 lbs | YES | NO |
| - Any other muscle or skeletal problem that interferes with using a respirator | YES | NO |

Signature of Employee

Date

FOR MEDICAL STAFF USE ONLY

EVALUATION OF POSITIVE RESPONSES IN PART A, SECTION 2

(List number and explanation) _____

PART B

ALL EMPLOYEES SELECTED TO USE ANY TYPE OF RESPIRATOR MUST ANSWER THE FOLLOWING QUESTIONS:

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen? **YES** **NO**
If yes, do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when working under these conditions? **YES** **NO**

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have your come into skin contact with hazardous chemicals? **YES** **NO**

If "yes," name the chemicals if you know them: _____

3. Have you ever worked with any of the materials or under any of the conditions listed below?

- | | | |
|---|------------|-----------|
| - Asbestos | YES | NO |
| - Silica (e.g., in sandblasting) | YES | NO |
| - Tungsten/cobalt (e.g., grinding or welding this material) | YES | NO |
| - Beryllium | YES | NO |
| - Aluminum | YES | NO |
| - Coal (e.g., mining) | YES | NO |
| - Iron | YES | NO |
| - Dusty environments | YES | NO |
| - Any other hazardous exposures | YES | NO |

If "yes," describe these exposures: _____

4. List any second job or side business that you have: _____

5. List your previous occupations: _____

6. List your current and previous hobbies: _____

7. Have you been in the military service? **YES** **NO**

If "yes," were you exposed to biological or chemical agents (either in training or combat)? **YES** **NO**

8. Have you ever worked on a **HAZMAT** team? **YES** **NO**

9. Other than medications for breathing or lung problems, heart trouble, blood pressure, and seizures mentioned earlier, are you taking any other medications for any reason (**include over-the-counter medications**) **YES** **NO**

If "yes," name of medications: _____

10. Will you be using any of the following items with your respirator(s)?
- | | | |
|-------------------------------|------------|-----------|
| - HEPA filters | YES | NO |
| - Canisters (e.g., gas masks) | YES | NO |
| - Cartridges | YES | NO |
11. How often are you expected to use the respirator(s)?
- | | | |
|------------------------------|------------|-----------|
| - Escape only (no rescue) | YES | NO |
| - Emergency rescue only | YES | NO |
| - Less than 5 hours per week | YES | NO |
| - Less than 2 hours per day | YES | NO |
| - 2 to 4 hours per day | YES | NO |
| - Over 4 hours per day | YES | NO |
12. During the period you are using the respirator(s), is your work effort:
- | | | |
|--|------------|-----------|
| - Light (less than 200 kcal per hour) | YES | NO |
|--|------------|-----------|
- If "yes," how long does this period last during the average shift:
 ___ hours ___ minutes Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs) or controlling machines.
- | | | |
|---|------------|-----------|
| - Moderate (200-350 kcal per hour) | YES | NO |
|---|------------|-----------|
- If "yes," how long does this period last during the average shift:
 ___ hours ___ minutes Examples of a moderate work effort are sitting while nailing or filing, driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs) at trunk level; walking on a level surface about 2 mph or down on a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs) on a level surface.
- | | | |
|--|------------|-----------|
| - Heavy (above 350 kcal per hour) | YES | NO |
|--|------------|-----------|
- If "yes," how long does this period last during the average shift:
 ___ hours ___ minutes Examples of a heavy work effort are lifting a heavy load (about 50 lbs) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs).
13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you are using your respirator?
- | | | |
|--|------------|-----------|
| | YES | NO |
|--|------------|-----------|
- If "yes," describe this protective clothing and/or equipment: _____

14. Will you be working under hot conditions (temp. exceeding 77° F)?
- | | | |
|--|------------|-----------|
| | YES | NO |
|--|------------|-----------|
15. Will you be working under humid conditions?
- | | | |
|--|------------|-----------|
| | YES | NO |
|--|------------|-----------|
16. Describe the work you will be doing while you are using your respirator(s): _____

17. Describe any special or hazardous conditions you might encounter when you are using your respirator(s), for example, confined spaces, life-threatening gas(es): _____

18. Provide the following information, if you know it, for each toxic substance that you will be exposed to when you are using your respirator(s):

Name of first toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of second toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of third toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

The name of any other toxic substances that you'll be exposed to while using your respirator(s): _____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (e.g., rescue, security): _____

Signature of Employee

Date