



OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Can you read? (Circle one) Yes / No

Your manager or supervisor must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain confidentiality, your manager or supervisor must not look at or review your answers, and he or she must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Section 1: Every employee who has been selected to use any type of respirator must, according to OSHA regulations, provide the following information. This information is not required for employees who voluntarily use dust masks for protection against nuisance dusts. (Please use ink and print)

<ol style="list-style-type: none"> 1. Today's date: _____ 2. Your name: _____ 3. Your age (to nearest year): _____ Date of Birth: _____ 4. Sex (circle one): Male Female 5. Your height: _____ 6. Your weight: _____ 7. Your job title: _____ 8. A Phone number where you can be reached by health care professional who reviews this questionnaire (include area code) (____) ____ - _____ 9. The best time to call you at this number: _____ AM PM 10. Has your employer told you how to contact the health care professional who will review this questionnaire? Yes No 11. Check the type of respirator that you will be using: <ol style="list-style-type: none"> a. _____ N, R, P filtering face piece respirator (For example, a dust mask or an N95 filtering face piece respirator) b. Circle all that apply: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">◆ Half Mask</td> <td style="width: 33%;">◆ Full face piece mask</td> <td style="width: 33%;">◆ Helmet hood</td> </tr> <tr> <td>◆ Non-powered cartridge or canister</td> <td>◆ Escape</td> <td>◆ Supplied air or Air-line</td> </tr> <tr> <td>◆ Powered air-purifying cartridge respirator (PAPR)</td> <td></td> <td></td> </tr> <tr> <td colspan="3">◆ Self-Contained Breathing Apparatus (SCBA): (check) ___ In Demand or ___ Pressure Demand</td> </tr> <tr> <td colspan="3">◆ Other: _____</td> </tr> </table> <p>Have you previously worn a respirator? Yes No If "yes", describe what type(s): _____</p>	◆ Half Mask	◆ Full face piece mask	◆ Helmet hood	◆ Non-powered cartridge or canister	◆ Escape	◆ Supplied air or Air-line	◆ Powered air-purifying cartridge respirator (PAPR)			◆ Self-Contained Breathing Apparatus (SCBA): (check) ___ In Demand or ___ Pressure Demand			◆ Other: _____			<p>B/P: _____</p> <p><u>Clinician Evaluation:</u></p>
◆ Half Mask	◆ Full face piece mask	◆ Helmet hood														
◆ Non-powered cartridge or canister	◆ Escape	◆ Supplied air or Air-line														
◆ Powered air-purifying cartridge respirator (PAPR)																
◆ Self-Contained Breathing Apparatus (SCBA): (check) ___ In Demand or ___ Pressure Demand																
◆ Other: _____																

Section 2- General Health Information

ALL employees must complete this section (Please circle “yes” or “no”)

- | | | | |
|-----------|--|------------|-----------|
| 1. | Do you currently 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? | | |
| | 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 (except when you have a cold): | Yes | No |
| 3. | Have you <i>ever had</i> any of the following? | | |
| | 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 have been told about: | Yes | No |
| 4. | Do you <i>currently</i> 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: | 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 breath deeply: | Yes | No |
| | n. Any other symptoms that you think may be related to lung problems: | Yes | No |
| 5. | Have you <i>ever had</i> 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. Hear arrhythmia (heart beating irregularly): | Yes | No |
| | g. High blood pressure: | Yes | No |
| | h. Any other heart problem that you have been told about | Yes | No |

- 6. Have you *ever 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 other 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 have used a respirator, have you *ever had* any of the following problems?**
(If you have never used a respirator, check this space ____ and go to question 9):
- | | | |
|--|------------|-----------|
| a. Eye irritation: | Yes | No |
| b. Skin allergies or rashes: | Yes | No |
| c. Anxiety that occurs when you use the respirator: | Yes | No |
| d. General or unusual weakness or fatigue: | Yes | No |
| e. Any other problem that interferes with the use of the respirator: | Yes | No |

- 9. Would you like to talk to the health care professional who will review this questionnaire?** Yes No

Section 3-
additional questions for users of full-face piece respirators or SCBA's
(Please circle "yes" or "No")

- | | | |
|--|------------|-----------|
| 1. Have you <i>ever lost</i> vision in either eye (temporarily or permanently)? | Yes | No |
| 2. Do you <i>currently have</i> any of these vision problems? | | |
| a. Need to wear contact lenses: | Yes | No |
| b. Need to wear glasses: | Yes | No |
| c. Color blindness: | Yes | No |
| d. Any other eye or vision problem: | Yes | No |
| 3. Have you <i>ever had</i> any injury to your ears, including a broken ear drum? | Yes | No |
| 4. Do you <i>currently have</i> any of these hearing problems? | | |
| a. Difficult hearing: | Yes | No |
| b. Need to wear hearing aid: | Yes | No |
| c. Any other hearing or ear problems: | Yes | No |
| 5. Have you <i>ever had</i> a back injury? | Yes | No |
| 6. Do you <i>currently have</i> 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 fully moving your arms and legs: | Yes | No |
| d. Pain or stiffness when you lean forward or backward at the waist: | Yes | No |
| e. Difficulty fully moving your head up or down: | Yes | No |
| f. Difficulty fully moving your head from side to side: | Yes | No |
| g. Difficulty bending at the knees: | Yes | No |
| h. Difficulty squatting to the ground: | Yes | No |
| i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs: | Yes | No |
| j. Any other muscle or skeletal problem that interferes with using a respirator: | Yes | No |

Section 4

1. In your present job, are you working at high altitudes (over 5,000ft) 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 you are working under these conditions: **Yes No**

2. Have you ever been exposed (At work or at home) to hazardous solvents, hazardous airborne chemicals (Such as gases, fumes, or dust), OR have you 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 following materials, or under any of the conditions listed below:

- a. Asbestos: **Yes No**
- b. Silica (for example, sand blasting): **Yes No**
- c. Tungsten/cobalt (for example, grinding or welding this material): **Yes No**
- d. Beryllium: **Yes No**
- e. Aluminum: **Yes No**
- f. Coal mining: **Yes No**
- g. Iron: **Yes No**
- h. Tin: **Yes No**
- i. Dusty environments: **Yes No**
- j. Any other hazardous exposures: **Yes No**

If "Yes", describe these exposures: _____

4. List any other second jobs or side businesses that you are involved in: _____

5. List your previous occupations: _____

6. List your current and previous hobbies: _____

7. Have you ever been in the military services? **Yes No**

If "Yes", were you exposed to any biological or chemical agents (either in training or combat)?

8. Have you ever worked on a HazMat team? **Yes No**

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over the counter medications)? **Yes No**

If "Yes", name the medications, if you know them: _____

10. Will you be using any of the following items with your respirator(s):

- a. HEPA filters: **Yes No**
- b. Canisters (for example, gas masks): **Yes No**
- c. Cartridges: **Yes No**

11. How often are you expected to use the respirator(s):

- a. Escape only, NO RESCUE: Yes No
- b. Emergency rescue only: Yes No
- c. Less than 5 hours per week: Yes No
- d. Less than 2 hours per day: Yes No
- e. 2 to 4 hours per day: Yes No
- f. Over 4 hours per day Yes No

12. During the period you are using the respirator(s), is your work effort:

- a. **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 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

- b. **Moderate** (200-350 kcal per hour) Yes No

If "Yes", how long does this period last during the average shift: _____Hours _____Minutes.

Examples of 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 a 5 degree grade at about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs) on a level surface.

- c. **Heavy** (about 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 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 (temperatures exceeding 77 degrees F):

Yes No

15. Will you be working under humid conditions:

Yes No

16. Describe the work you will be doing while using your respirator:

Yes No

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

Yes No

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 Toxic Substance:	Estimated maximum exposure level per shift:	Duration of exposure level per shift:

