Occupational Health Clinical Center
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OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Company Name:_____

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

Date: _____

Name: _____ DOB: _____ Age: _____

Sex: □ Male □ Female Height: _____ft. _____in. Weight:_____lbs.

Job title: _____

Phone number: ( )_____ *where the health care professional reviewing the form can reach you

Best time to reach you: _____

Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes No

Check the **type of respirator you will use** (you can check more than one category):

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

□ Other type (for example, half-facepiece or full-facepiece type, powered-air purifying, supplied-air, self-breathing apparatus).

Have you worn a respirator (check one): □ No □ Yes

If **YES** what type (s): _____

How often? _____

1 Dust mask / Surgical Mask / Disposable mask	
2 Half-face respirator	
3 Full-face respirator	

Part A. Section 2. Questions below must be answered. Please **explain** any **YES** answers.

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month?

□ No □ Yes **If yes, how much and how long?** _____

Have you ever smoked? □ No □ Yes **If yes, how long & when did you quit?** _____

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

□ No □ Yes Seizures (fits) _____

□ No □ Yes Diabetes (sugar disease) _____

□ No □ Yes Allergic reactions that interfere with breathing _____

□ No □ Yes Claustrophobia (fear of closed-in places) _____

□ No □ Yes Trouble Smelling Odors _____

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

□ No □ Yes Asbestosis _____

□ No □ Yes Asthma _____

□ No □ Yes Chronic bronchitis _____

□ No □ Yes Emphysema _____

□ No □ Yes Pneumonia _____

□ No □ Yes Tuberculosis _____

□ No □ Yes Silicosis _____

□ No □ Yes Pneumothorax (collapsed lung) _____

□ No □ Yes Lung cancer _____

□ No □ Yes Broken ribs _____

□ No □ Yes Any chest injuries or surgeries _____

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

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

□ No □ Yes Shortness of breath _____

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

□ No □ Yes Shortness of breath when walking with others at an ordinary pace on level ground

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

□ No □ Yes Shortness of breath when washing or dressing yourself _____

□ No □ Yes Shortness of breath that interferes with your job _____

□ No □ Yes Coughing that produces phlegm (thick sputum) _____

□ No □ Yes Coughing that wakes you early in the morning _____

□ No □ Yes Coughing that occurs mostly when you are lying down _____

□ No □ Yes Coughing up blood in the last month _____

□ No □ Yes Wheezing _____

□ No □ Yes Wheezing that interferes with your job _____

□ No □ Yes Chest pain when you breathe deeply _____

□ No □ Yes Any other symptoms that you thing may be related to lung problems _____

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

□ No □ Yes Heart attack _____

□ No □ Yes Stroke _____

□ No □ Yes Angina _____

□ No □ Yes Heart failure _____

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

□ No □ Yes Heart arrhythmia (heart beating irregularly) _____

□ No □ Yes High blood pressure _____

□ No □ Yes Any other heart problem that you've been told about _____

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

□ No □ Yes Frequent pain or tightness in your chest _____

□ No □ Yes Pain or tightness in your chest during physical activity _____

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

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

□ No □ Yes Heartburn or indigestion that is not related to eating _____

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

_____

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

□ No □ Yes Breathing or lung problems _____

□ No □ Yes Heart trouble _____

□ No □ Yes Blood pressure _____

□ No □ Yes Seizures (fits) _____

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

□ No □ Yes ***(If you've never used a respirator, check the following space and go to question 9)***

□ No □ Yes Eye irritation _____

□ No □ Yes Skin allergies or rashes _____

□ No □ Yes Anxiety _____

□ No □ Yes General weakness or fatigue _____

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

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

□ No □ Yes

10. Have you **ever lost** vision in either eye (temporarily or permanently)?

□ No □ Yes _____

11. Do you **currently** have any of the following vision problems

□ No □ Yes Wear contact lenses

□ No □ Yes Wear glasses

□ No □ Yes Color blind

□ No □ Yes Any other eye or vision problems _____

12. Have you **ever had** any injury to your ears, including a broken ear drum?

□ No □ Yes _____

13. Do you **currently** have any of the following hearing problems?

□ No □ Yes Difficulty hearing _____

□ No □ Yes Wear a hearing aid _____

□ No □ Yes Any other hearing or ear problem _____

14. Have you **ever had** a back injury?

□ No □ Yes _____

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

□ No □ Yes Weakness in any of your arms, hands, legs, or feet _____

□ No □ Yes Back pain _____

□ No □ Yes Difficulty fully moving your arms and legs _____

□ No □ Yes Pain or stiffness when you lean forward or backward at the waist _____

□ No □ Yes Difficulty fully moving your head up or down _____

□ No □ Yes Difficulty fully moving your head side to side _____

□ No □ Yes Difficulty bending at your knees _____

□ No □ Yes Difficulty squatting to the ground _____

□ No □ Yes Climbing a flight of stairs or a ladder carrying more than 25 lbs _____

□ No □ Yes Any other muscle or skeletal problem that interferes with using a respirator _____

Please Be Certain to Explain All Positive Responses

Part B

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:

□ No □ Yes

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions:

□No □ Yes

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 you come into skin contact with hazardous chemicals:

□ No □ Yes 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:

□ No □ Yes Asbestos

□ No □ Yes Silica (**e.g.**, in sandblasting)

□ No □ Yes Tungsten/cobalt (e.g., grinding or welding this material)

□ No □ Yes Beryllium

□ No □ Yes Aluminum

□ No □ Yes Coal (for example, mining)

□ No □ Yes Iron

□ No □ Yes Tin

□ No □ Yes Dusty environments

□ No □ Yes Any other hazardous exposures

If "yes," describe these exposures: _____
_____
_____

4. List any second jobs or side businesses you have: _____
_____

5. List your previous occupations: _____
_____

6. List your current and previous hobbies: _____
_____

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

□ No □ Yes If "yes," were you **exposed to biological or chemical agents** (either in training or combat)

_____

8. □ No □ Yes Have you ever worked on a HAZMAT team?

9. □ No □ Yes 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)?

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

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

□ No □ Yes HEPA Filters

□ No □ Yes Canisters (for example, gas masks)

□ No □ Yes Cartridges

11. How often are you expected to use the respirator(s) yes or no for all answers that apply to you):

□ No □ Yes Escape only (no rescue)_____

□ No □ Yes Emergency rescue only _____

□ No □ Yes Less than 5 hours **per week** _____

□ No □ Yes Less than 2 hours **per day** _____

□ No □ Yes 2 to 4 hours per day _____

□ No □ Yes Over 4 hours per day _____

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

□ No □ Yes **Light** (less than 200 kcal per hour)

If "yes," how long does this period last during the average shift:_____hrs._____mins.

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.

□ No □ Yes **Moderate** (200 to 350 kcal per hour)

If "yes," how long does this period last during the average shift:_____hrs._____mins.

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 about 3 mph; or **pushing** a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

□ No □ Yes **Heavy** (above 350 kcal per hour)

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of 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're using your respirator

□ No □ Yes If "yes," describe this protective clothing and/or equipment:_____
_____

14. □ No □ Yes Will you be working under hot conditions (temperature exceeding 77 deg. F)

15. □ No □ Yes Will you be working under humid conditions

16. Describe the work you'll be doing while you're using your respirator(s):
_____
_____

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

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

Name of the first toxic substance: _____
Estimated maximum exposure level per shift: _____
Duration of exposure per shift: _____
Name of the second toxic substance: _____
Estimated maximum exposure level per shift: _____
Duration of exposure per shift: _____
Name of the 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:
_____
_____
_____

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

Reviewed by:_____

(signature)

OFFICE USE ONLY

☐	Co-workers at risk:	Yes	No
☐	Co-workers similarly protected:	Yes	No
☐	IH involvement initiated:	Yes	No
☐	IH involvement not indicated:	Reason:_____	