OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Name: ___________________________ Employee Number: ______________

Job Title: __________________________ Item #: ______________

To the Employee:

Can you read English? Yes ____  No ____ If "No" who helped you to understand and complete this questionnaire?

Name __________________________ Relationship __________________________

Your employer must allow you to answer the 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.

Section 1. The following information must be provided by every employee who has been selected to use any type of respirator (please print.)

1. Today’s date: ______________________
2. Sex (circle one) Male  Female
3. Your height _______ ft. _______ inch.
4. Your weight: ___________ lbs.
5. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the area code): ______________________________
6. The best time to phone you at this number: __________________________
7. Has your employer told you how to contact the health care professional who will review this questionnaire? Yes ______ No ______
8. Check the type of respirator you will use (you can check more than one category)
   ____ N, R, or P disposable (filter-mask, non-cartridge type only)
   ____ Other type (for example, half or full-facepiece type, powered air purifying, supplied-air, SCBA)
9. Have you worn a respirator? Yes _____ No _____
   If “Yes,” what type(s)? __________________________

Section 2. Please answer each question by circling “Yes” or “No”

Yes  No  1. Do you currently smoke tobacco, or have you smoked tobacco in the past month?
2. Have you ever had any of the following conditions?
   Yes  No  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

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

Yes  No  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’ve been told about (Please describe)

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

Yes  No  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 (thick sputum)
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 breathe deeply
Yes  No  n. Any other symptoms that you think may be related to lung problems
   (Please describe)

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

Yes  No  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. Heart arrhythmia (heart beating irregularly)
Yes  No  g. High blood pressure
Yes  No  h. Any other heart problem that you’ve been told about. (Please describe)

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

Yes  No  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?
   (Please describe)

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

Yes  No  a. Breathing or lung problems
Yes  No  b. Heart trouble
Yes  No  c. Blood pressure
Yes  No  d. Seizures (fits)
Name: _____________________________________________________________

8. Have you used a respirator before?
   If “No” please skip to question #9. If “Yes”, have you ever had any of the following problems?
   Yes No a. Eye irritation
   Yes No b. Skin allergies or rashes
   Yes No c. Anxiety
   Yes No d. General weakness or fatigue
   Yes No e. Any other problem that interferes with your use of a respirator
   (Please describe)

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)

11. Do you currently have any of the following vision problems?
   Yes No a. Wear contact lenses
   Yes No b. Wear glasses
   Yes No c. Color blind
   Yes No d. Any other eye or vision problem (Please describe)

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

13. Do you currently have any of the following hearing problems?
   Yes No a. Difficulty hearing
   Yes No b. Wear a hearing aid
   Yes No c. Any other hearing or ear problem (Please describe)

14. Have you ever had a back injury?

15. Do you currently have any of the following musculoskeletal problems?
   Yes No 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 and 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 your 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
   (Please describe)

If you need to describe a problem in more detail, please use the space below (please write the question #)