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 us to 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)

B/P: ______________

Clinician Evaluation:

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:
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:

- 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: _______________________________

Have you previously worn a respirator? **Yes** **No**
If "yes", describe what type(s): ____

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 *ever had* 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 *ever had* 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 *currently* 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 *ever had* 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 *ever lost* vision in either eye (temporarily or permanently)? Yes No

2. Do you *currently have* 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 *ever had* any injury to your ears, including a broken ear drum? Yes No

4. Do you *currently have* 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 *ever had* a back injury? Yes No

6. Do you currently have 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:

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

Please explain all "Yes" responses:

Item Number:	Explanation:

I shall report to management any changes in my health condition that are related to my ability to use a respirator.

I hereby certify that they answers to the above questions are true to the best of my knowledge.

____

Employee's signature: **Date:**

____

Clinician's signature: **Date:**