OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

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 profession who will review it.

Part A. Section 1. (Mandatory) 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. Employee Name_____
3. Social Security #_____
4. Sex (circle one) Male Female
5. Height_____ft_____in
6. Weight_____Date of Birth_____
7. Employee job title_____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire_____
   _____
9. The best time to phone you at this number_____
   _____
10. ☐ Yes ☐ No Has your employer told you how to contact the healthcare professional who will review this questionnaire?
11. Check the type of respirator you will use (you may check more than one category):
    - ☐ N, R or P disposable respirator (filter mask, non-cartridge type only).
    - ☐ Other type; i.e., half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus)
12. ☐ Yes ☐ No Have you worn a respirator? If "yes", what type(s)_____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. (Please check "Yes" or "No")

1. ☐ Yes ☐ No Do you *currently* smoke tobacco or have you smoked tobacco in the last month?
2. Have you ever had any of the following conditions:
   a) ☐ Yes ☐ No Seizures (fits)?
   b) ☐ Yes ☐ No Diabetes (sugar disease)?
   c) ☐ Yes ☐ No Allergic reactions that interfere with your breathing?
   d) ☐ Yes ☐ No Claustrophobia?
   e) ☐ Yes ☐ No Trouble smelling odors?
3. Have you *ever had* any of the following pulmonary or lung problems:
   a) ☐ Yes ☐ No Asbestosis?
   b) ☐ Yes ☐ No Asthma?
   c) ☐ Yes ☐ No Chronic bronchitis?
   d) ☐ Yes ☐ No Emphysema?
   e) ☐ Yes ☐ No Pneumonia?
   f) ☐ Yes ☐ No Tuberculosis?
   g) ☐ Yes ☐ No Silicosis?
   h) ☐ Yes ☐ No Pneumothorax (collapsed lung)?
   i) ☐ Yes ☐ No Lung cancer?
   j) ☐ Yes ☐ No Broken ribs?
   k) ☐ Yes ☐ No Any chest injuries or surgeries?
   l) ☐ Yes ☐ No Any other lung problem that you've been told about?
4. Do you currently have any of the following symptoms of pulmonary or lung disease:
   a) ☐ Yes ☐ No Shortness of breath?
   b) ☐ Yes ☐ No Shortness of breath when walking fast on level ground or walking up a slight hill or incline?
   c) ☐ Yes ☐ No Shortness of breath when walking with other people at an ordinary pace on level ground?
   d) ☐ Yes ☐ No Have to stop for breath when walking at your own pace on level ground?
   e) ☐ Yes ☐ No Shortness of breath when washing or dressing yourself?
   f) ☐ Yes ☐ No Shortness of breath that interferes with your job?
   g) ☐ Yes ☐ No Coughing that produces phlegm?
   h) ☐ Yes ☐ No Coughing that wakes you early in the morning?
   i) ☐ Yes ☐ No Coughing that occurs mostly when you are lying down?
   j) ☐ Yes ☐ No Coughing up blood in the last month?
   k) ☐ Yes ☐ No Wheezing?
   l) ☐ Yes ☐ No Wheezing that interferes with your job?
   m) ☐ Yes ☐ No Chest pain when you breathe deeply?
   n) ☐ Yes ☐ No Any other symptoms that you think may be related to lung problems?

5. Have you *ever had* any of the following cardiovascular or heart problems:
   a) ☐ Yes ☐ No Heart attack?
   b) ☐ Yes ☐ No Stroke?
   c) ☐ Yes ☐ No Angina?
   d) ☐ Yes ☐ No Heart failure?
   e) ☐ Yes ☐ No Swelling in your legs or feet (not caused by walking)?
   f) ☐ Yes ☐ No Heart arrhythmia (heart beating irregularly)?
   g) ☐ Yes ☐ No High blood pressure?
   h) ☐ Yes ☐ No Any other heart problem that you've been told about?

6. Have you *ever had* any of the following cardiovascular or heart problems:
   a) ☐ Yes ☐ No Frequent pain or tightness?
   b) ☐ Yes ☐ No Pain or tightness in your chest during physical activity?
   c) ☐ Yes ☐ No Pain or tightness in your chest that interferes with your job?
   d) ☐ Yes ☐ No In the past two years, have you noticed your heart skipping or missing a beat?
   e) ☐ Yes ☐ NoHeartburn or indigestion that is not related to eating?
   f) ☐ Yes ☐ No 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:
   a) ☐ Yes ☐ No Breathing or lung problems?
   b) ☐ Yes ☐ No Heart trouble?
   c) ☐ Yes ☐ No Blood pressure?
   d) ☐ Yes ☐ No Seizures (fits)?

8. If you've used a respirator, have you *ever had* any of the following problems:
   a) ☐ Yes ☐ No Eye irritation?
   b) ☐ Yes ☐ No Skin allergies or rashes?
   c) ☐ Yes ☐ No Anxiety?
   d) ☐ Yes ☐ No General weakness or fatigue?
   e) ☐ Yes ☐ No Any other problem that interferes with your use of a respirator?

9. ☐ Yes ☐ No Would you lilke to talk with the health care professional who will review this questionnaire about your answers to this questionnaire?

Questions 10 through 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. ☐ Yes ☐ No Have you *ever lost* vision in either eye (temporarily or permanently)?
11. Do you *currently* have any of the following vision problems:
    a) ☐ Yes ☐ No Wear contact lenses?
    b) ☐ Yes ☐ No Wear glasses?
    c) ☐ Yes ☐ No Color blind?
    d) ☐ Yes ☐ No Any other eye or vision problems?
12. ☐ Yes ☐ No 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:
    a) ☐ Yes ☐ No Difficulty hearing?
    b) ☐ Yes ☐ No Wear a hearing aid?
    c) ☐ Yes ☐ No Any other hearing or ear problems?
14. ☐ Yes ☐ No Have you *ever had* a back injury?
15. Do you currently have any of the following musculoskeletal problems:
    a) ☐ Yes ☐ No Weakness in any of your arms, hands, legs or feet?
    b) ☐ Yes ☐ No Back pain?
    c) ☐ Yes ☐ No Difficulty moving your arms and legs?
    d) ☐ Yes ☐ No Pain or stiffness when you lean forward or backward at the waist?
    e) ☐ Yes ☐ No Difficulty moving your head up or down?
    f) ☐ Yes ☐ No Difficulty moving your head side to side?
    g) ☐ Yes ☐ No Difficulty bending at your knees?
    h) ☐ Yes ☐ No Difficulty squatting to the ground?
    i) ☐ Yes ☐ No Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.?
    j) ☐ Yes ☐ No Any other muscle or skeletal problem that interferes with using a respirator?

Part B. Any of the following questions and other questions not listed may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. ☐ Yes ☐ No In your present job, are you working at high altitudes (over 5,000 ft) or in a place that has lower than normal amounts of oxygen? 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? ☐ Yes ☐ No

2. ☐ Yes ☐ No At work or 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? 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:
   a) ☐ Yes ☐ No Asbestos?
   b) ☐ Yes ☐ No Silica (sandblasting)?
   c) ☐ Yes ☐ No Tunsten/cobalt (grinding or welding this material)?
   d) ☐ Yes ☐ No Beryllium?
   e) ☐ Yes ☐ No Aluminum?
   f) ☐ Yes ☐ No Coal (for example, mining)?
   g) ☐ Yes ☐ No Iron?
   h) ☐ Yes ☐ No Tin?
   i) ☐ Yes ☐ No Dust environments?
   j) ☐ Yes ☐ No Any other hazardous exposures?
   k) 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. ☐ Yes ☐ No Have you been in the military services? If "yes," were you exposed to biological or chemical agents (either in training or combat) ☐ Yes ☐ No
8. ☐ Yes ☐ No Have you ever worked on a HAZMAT team?
9. ☐ Yes ☐ No 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):
    a) ☐ Yes ☐ No HEPA filters?
    b) ☐ Yes ☐ No Canisters; i.e., gas masks?
    c) ☐ Yes ☐ No Cartridges?
11. How often are you expected to use the respirator(s) (check "yes" or "no" for all answers that apply):
    a) ☐ Yes ☐ No Escape only (no rescue)?
    b) ☐ Yes ☐ No Emergency rescue only?
    c) ☐ Yes ☐ No Less than 5 hours per week?
    d) ☐ Yes ☐ No Less than 2 hours per day?
    e) ☐ Yes ☐ No 2 to 4 hours per day?
    f) ☐ Yes ☐ No Over 4 hours per day?
12. During the period you are using the respirator(s), is your work effort:
    a) ☐ Yes ☐ No Light (less than 200kcal 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.
    b) ☐ Yes ☐ No Moderate (200 to 350 kcal per hour). If "yes," how long does this period last during the average shift:____hrs.____mins. 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 a 5-degree grade about 3 mph or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.
    c) ☐ Yes ☐ No 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 2mph; *climbing* stairs with a heavy load (about 50 lbs.).
13. ☐ Yes ☐ No Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using the respirator? If "yes," describe the protective clothing and/or equipment _____
    _____
14. ☐ Yes ☐ No Will you be working under hot conditions (temperature exceeding 77°F)?
15. ☐ Yes ☐ No Will you working under humid conditions?
16. Describe the work you'll be doing while you're using the respirator(s)_____
17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s); i.e., 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):
    a) Name of the first toxic substance_____
    _____
    b) Estimated maximum exposure level per shift_____
    _____
    c) Duration of the exposure per shift_____
    _____
    d) Name of the second toxic substance_____
    _____
    e) Estimated maximum exposure level per shift_____
    _____
    f) Duration of the exposure per shift_____
    _____
    g) Name of the third toxic substance_____
    _____
    h) Estimated maximum exposure level per shift_____
    _____
    i) Duration of the exposure per shift_____
    _____
    j) The name of any other toxic substances that you'll be exposed to 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; i.e., rescue, security:_____
    _____
    _____

Please email the completed form to occmed@owensborohealth.org