PRINCE WILLIAM Occupational Health

OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

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

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. Name:____
3. Age:
4. Sex: (circle one): Male/Female
5. Ht.____________Ft.__________in.____________
6. Weight: _____________________Ibs.
7. Your job title:____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire: (include Area Code):__________________
9. The best time to phone you at this number:___________________________________
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 you will use (you can check more than one category):
   a. ______ N, R, or p disposable respirator (filter-mask, non- cartridge type only)
   b. ______ Other type (for example, half or full face piece type, powered-air purifying, supplied air, self-contained breathing apparatus).
12.Have you worn a respirator (circle one): YES/NO
   If "YES" what type(s): ____

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

1. **Do you currently smoke tobacco, or have you smoked 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: Yes/No

3. **Have you <u>ever had</u> any of the following pulmonary or lung problems?** Yes/No

a.	Asbestosis:	Yes/No	h.	Pneumothorax (collapsed lung):	Yes/No
b.	Asthma:	Yes/No	i.	Lung cancer:	Yes/No
c.	Chronic bronchitis:	Yes/No	j.	Broken ribs:	Yes/No
d.	Emphysema:	Yes/No	k.	Any chest injuries or surgeries:	Yes/No
e.	Pneumonia:	Yes/No	l.	Any other lung problem you have been told about:	Yes/No
f.	Tuberculosis:	Yes/No			
g.	Silicosis:	Yes/No			

4. **Do you <u>currently</u> 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:	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:	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. Heart arrhythmia (heart beating irregularly):	Yes/No
g. High blood pressure:	Yes/No
h. Any other heart problem that you've 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:	Yes/No

8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check the following space and go to question 9:) Have never used a respirator____________

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: Yes/No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers: Yes/No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece 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. Have you *ever lost* vision in either eye (temporarily or permanently): Yes/No

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

a. Wear contact lenses: Yes/No
b. Wear glasses: Yes/No
c. Color blind: Yes/No
d. Any other eye or vision problem: Yes/No

12. Have you *ever had* an injury to your ears, including a broken ear drum: Yes/No

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

a. Difficulty hearing: Yes/No
b. Wear a hearing aid: Yes/No
c. Any other hearing or ear problem: Yes/No

14. Have you *ever had* a back injury: Yes/No

15. 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 head up or down: Yes/No
d. Pain or stiffness when you lean forward or backward at the waist: Yes/No
e. Difficulty fully moving your arms or legs: Yes/No
f. Difficulty bending at your knees: Yes/No
g. Difficulty squatting to the ground: Yes/No
h. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes/No
i. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

Signature:____ Date:_______________________________