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 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
  h. Pneumothorax (collapsed lung): Yes/No
  i. Lung cancer: Yes/No
  j. Broken ribs: Yes/No

d. Emphysema: Yes/No
e. Pneumonia: Yes/No
f. Tuberculosis: Yes/No
g. Silicosis: Yes/No
k. Any chest injuries or surgeries: Yes/No
l. Any other lung problem you have been told about: 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:_______________________________