OSHA Respirator
Medical Evaluation Questionnaire

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 professional 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 or respirator. **(Please print).**

1. Today's Date: _____

2. Your Name: _____

3. Your age (to the nearest year): _____

4. Sex (circle one): Male/Female

5. Your height: _____ ft. _____ in.

6. Your weight: _____ lbs.

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 healthcare professional who will review this questionnaire (circle one). Yes/No

11. Check the type of respirator you will use (you can check more than one category):

- ____N,R, or P disposable respirator (filter-mask, non cartridge type only).
- ____ 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

13. If "yes", what type(s): _____

Respirator Medical Evaluation Questionnaire

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 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? Yes No

- Seizures (fits) Yes No
- Diabetes (Sugar disease) Yes No
- Allergic reactions that interfere with your breathing Yes No
- Claustrophobia (fear of closed in places) Yes No
- Trouble smelling odors Yes No

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

- 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 problems that you've 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 ground level Yes No
- D. Have to stop 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 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 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 medications for the following problems?

A. Breathing or Lung problems Yes No
B. Heart problems Yes No
C. Blood pressure Yes No
D. Seizures (fits) Yes No

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

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 respirator Yes No

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

QUESTIONS 10-15 BELOW MUST BE ANSWERED BY EVERY EMPLOYEE WHO HAS BEEN SELECTED TO USE EITHER A FULL-FACEPIECE RESPIRATOR OR A SELF-CONTAINED BREATHING APPRATUS (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 visions problems?

a. Wear contact lens 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. Difficult hearing Yes No
b. Wear a hearing aid Yes No
c. Any other hearing problems 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 arms or 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 side to side Yes No
g. Difficulty bending at your knees Yes No
h. Difficulty squatting to the ground Yes No
i. 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

Part B. The health care provider who will be reviewing this document has selected the following questions.

1. At work or at 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: Yes No

If "Yes", name the chemicals if you know them: _____

_____

2. Have you ever worked with any of the following materials, or under any of the conditions listed below:

a. Asbestos	Yes No
b. Silica (e.g., in sandblasting)	Yes No
c. Tungsten/colbalt (e.g., grinding or welding this material)	Yes No
d. Berylium	Yes No
e. Aluminum	Yes No
f. Coal (For example, mining)	Yes No
g. Iron	Yes No
h. Tin	Yes No
i. Dusty environment	Yes No
j. Any other hazardous exposures	Yes No

If "yes" , describe these exposures: _____

_____

3. List any second jobs or side businesses you have: _____

_____

4. List your previous occupations: _____

_____

5. List your current and previous hobbies: _____

_____

6. Have you been in the military services? Yes No

If "yes" , were you exposed to biological or chemical agents
(either in training or combat) Yes No

7. Have you ever worked on a HAZMAT Team? Yes No

8. 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

9. 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

10. How often are you expected to use the respirator(s)? ("yes" or "no" for all answers that apply to you):

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

11. During the period you are using the respirator(s), is your work effort:

a. Light (less than 200 kcal per hour)

Examples are sitting while writing, typing, drafting, or performing light assembly work; or **standing** while operating a drill press (1-3 lbs.) or controlling machines. **Yes No**

If "yes" how long does this period last during the average shift?

Hrs Min.

b. Moderate (200 to 350 kcal per hour)

Examples 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. **Yes No**

If "yes" how long does this period last during the average shift?

_____ **Hrs** _____ **Min.**

c. Heavy (Above 350 kcal per hour)

Examples 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.) **Yes No**

If "yes" how long does this period last during the average shift?

_____**Hrs** _____ **Min.**

12. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator? **Yes No**

If "yes" describe this protective clothing and/or equipment:

13. Will you be working under hot conditions (temperature exceeding 77 deg. F)? Yes No

14. Will you be working under humid conditions? Yes No

15. Describe the work you'll be doing while you're using your respirator(s): _____

_____

_____

16. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (For example, confined spaces, life-threatening gases): _____

_____

_____

17. 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):

Name of the first toxic substance:_____
Estimated maximum exposure level per shift: _____
Duration of exposure per shift: _____

Name of the second toxic substance:_____
Estimated maximum exposure level per shift: _____
Duration of exposure per shift: _____

Name of the third toxic substance:_____
Estimated maximum exposure level per shift: _____
Duration of exposure per shift: _____

Name of any other toxic substances that you'll be exposed to while using your respirator: _____

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

_____

_____

_____