Name ______________________________________ Date _____________________________

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Can you read well enough to answer the Questionnaire? Yes / No

The following information must be provided by every employee who has been selected to use any type of respirator

1. Your age: ____________

2. Sex (circle one): Male/Female

3. Your height: ____ ft. _____ in.

4. Your weight: ________ lbs.

5. Your job title: ____________________________

6. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): (______) ______ - ___________

7. The best time to phone you at this number: ________________

8. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes / No

9. 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).

10. Have you ever worn a respirator: Yes / No
   If "yes," what type(s):
   ____
   ____

11. Do you currently smoke tobacco, or have you smoked tobacco in the last month: Yes / No

12. Have you ever had any of the following conditions?
   a. Seizures (fits) Yes / No
   b. Diabetes 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

13. 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 problem that you've been told about: Yes / No

14. 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 (thick sputum): Yes / No
   h. Coughing that wakes you early in the morning: Yes / No
   i. Coughing that occurs 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

15. 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

16. 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

17. 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

18. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, go to question 19 :)
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

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

20. In your present job, are you working at high altitudes (over 5,000 feet) 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're working under these conditions: Yes / No

21. 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:______________________

22. Have you ever worked with any of the materials, or under any of the conditions listed below?
a. Asbestos: Yes / No
b. Silica (e.g., in sandblasting): Yes / No
c. Tungsten/cobalt (e.g., grinding or welding this material): Yes / No
d. Beryllium: Yes / No
e. Aluminum: Yes / No
f. Coal (i.e., mining):
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.
____
____

23. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you):
a. Escape only: 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

Questions 24 to 28 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.

24. Have you ever lost vision in either eye (temporarily or permanently)? Yes / No
25. 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
e. Any other eye or vision problem: Yes / No

26. Have you ever had an injury to your ears, including a broken ear drum? Yes / No
27. 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

28. Have you ever had a back injury? Yes / No

29. 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 side to side: 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

Health Care Professional Comments:
____
____
____
____
____

____
Health Care Professional Signature

____

Examinee Signature:

____