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

**Today’s Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Age**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender**: [ ] Male [ ] Female **Height**:\_\_\_\_\_\_\_\_\_\_\_\_feet \_\_\_\_\_\_\_\_\_\_\_\_\_\_inches **Weight**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_pounds (lbs)

**Phone Number** (include area code)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Best time of day to call**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Job Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1**. Has your employer informed you about how to contact the health care professional who will review this questionnaire? [ ] Yes [ ] No
**2**. Check the type of respirator you will be using (select all that apply):
 [ ] N, R, or P disposable respirator, filter mask, non-cartridge type only
 [ ] Other type—half or full face piece type, powered air purifying, supplied air, self-contained breathing apparatus, etc.
**3**. Do you currently smoke tobacco, or have you smoked tobacco in the last month? [ ] Yes [ ] No

|  |  |  |  |
| --- | --- | --- | --- |
| **4**. | *YES* | *NO* | *Have you ever had any of the following conditions?* |
|  |[ ] [ ]  Seizures (fits) |
|  |[ ] [ ]  Diabetes |
|  |[ ] [ ]  Allergic reactions that interfere with your breathing |
|  |[ ] [ ]  Claustrophobia (fear of closed-in places) |
|  |[ ] [ ]  Trouble smelling orders |
|  |  |  |  |
| **5**. | *YES* | *NO* | *Do you currently take medication for any of the following problems?* |
|  |[ ] [ ]  Breathing or lung problems |
|  |[ ] [ ]  Heart problems |
|  |[ ] [ ]  Blood pressure |
|  |[ ] [ ]  Seizures (fits) |
|  |  |  |  |
| **6**. | *YES* | *NO* | *Have you ever had any of the following pulmonary or lung problems?* | *YES* | *NO* | *Have you ever had any of the following pulmonary or lung problems?* |
|  |[ ] [ ]  Asbestosis |[ ] [ ]  Silicosis |
|  |[ ] [ ]  Asthma |[ ] [ ]  Pneumothorax (collapsed lung) |
|  |[ ] [ ]  Chronic bronchitis |[ ] [ ]  Lung cancer |
|  |[ ] [ ]  Emphysema |[ ] [ ]  Broken ribs |
|  |[ ] [ ]  Pneumonia |[ ] [ ]  Chest injuries or surgeries |
|  |[ ] [ ]  Tuberculosis |  |  |  |
|  |[ ] [ ]  Any other lung problem, list problem(s) here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| **7**. | *YES* | *NO* | *Do you currently have any of the following symptoms of pulmonary or lung illness?* |
|  |[ ] [ ]  Shortness of breath |
|  |[ ] [ ]  Shortness of breath when walking fast on level ground or walking up a slight hill or incline |
|  |[ ] [ ]  Shortness of breath when walking with other people at an ordinary pace on level ground |
|  |[ ] [ ]  Having to stop for breath when walking at your own pace on level ground |
|  |[ ] [ ]  Shortness of breath when washing or dressing yourself |
|  |[ ] [ ]  Shortness of breath that interferes with your job |
|  |[ ] [ ]  Coughing that produces phlegm (thick sputum) |
|  |[ ] [ ]  Coughing that wakes you early in the morning |
|  |[ ] [ ]  Coughing that occurs when you are lying down |
|  |[ ] [ ]  Coughing up blood in the last month |
|  |[ ] [ ]  Wheezing |
|  |[ ] [ ]  Wheezing that interferes with your job |
|  |[ ] [ ]  Chest pain when you breathe deeply |
|  |[ ] [ ]  Any other symptoms that you think may be related to lung problems |
|  |
| **8**. | *YES* | *NO* | *Have you ever had any of the following?* | *YES* | *NO* | *Have you ever had any of the following?* |
|  |[ ] [ ]  Heart attack |[ ] [ ]  Swelling in your legs or feet, not caused by walking |
|  |[ ] [ ]  Stroke |[ ] [ ]  Heart arrhythmia (heart beating irregularly) |
|  |[ ] [ ]  Angina (chest pain) |[ ] [ ]  High blood pressure |
|  |[ ] [ ]  Heart failure |  |  |  |
|  |[ ] [ ]  Any other heart problem, list problem(s) here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE, PAGE 1 OF 2
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|  |  |  |  |
| --- | --- | --- | --- |
| **9**. | *YES* | *NO* | *Have you ever had any of the following cardiovascular or heart symptoms?* |
|  |[ ] [ ]  Frequent pain or tightness in your chest |
|  |[ ] [ ]  Pain or tightness in your chest during physical activity |
|  |[ ] [ ]  Pain or tightness in your chest that interferes with your job |
|  |[ ] [ ]  Your heart skipping or missing a beat, in the past two years |
|  |[ ] [ ]  Heartburn or indigestion that is not related to eating |
|  |[ ] [ ]  Heart arrhythmia (heart beating irregularly) |
|  |[ ] [ ]  High blood pressure |
|  |[ ] [ ]  Any other symptoms that you think may be related to heart or circulation problems |

**10**. Have you ever worn a respirator? [ ] Yes (*please answer questions below)* [ ] No (*skip to question 11*)

|  |  |  |
| --- | --- | --- |
| *YES* | *NO* | *Did you have any of the following problems while using your respirator?* |
|[ ] [ ]  Eye irritation |
|[ ] [ ]  Skin allergies or rashes |
|[ ] [ ]  Anxiety |
|[ ] [ ]  General weakness or fatigue |
|[ ] [ ]  Any other problem that interfered with your use of a respirator |

 Type(s) of respirator worn\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Questions 11-16 are only required for employees who have 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 questions 11-16 is voluntary.**

**11**. Have you ever lost vision in either eye? [ ] Yes, temporarily [ ] Yes, permanently [ ] No

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **12**. | *YES* | *NO* | *Do you currently have any of the following vision problems?* | *YES* | *NO* | *Do you currently have any of the following hearing problems?* |
|  |[ ] [ ]  Wear contact lenses |[ ] [ ]  Difficulty hearing |
|  |[ ] [ ]  Wear glasses |[ ] [ ]  Wear a hearing aid |
|  |[ ] [ ]  Color blind |[ ] [ ]  Any other ear or hearing problem, list problem(s) here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |[ ] [ ]  Any other eye or vision problem, list problem(s) here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

 **13**. Have you ever had an injury to your ears, including a broken ear drum? [ ] Yes [ ] No

**14**. Have you ever had a back injury? [ ] Yes [ ] No

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **15**. | *YES* | *NO* | *Do you currently have any of the following musculoskeletal problems?* | *YES* | *NO* | *Do you currently have any of the following musculoskeletal problems?* |
|  |[ ] [ ]  Weakness in any of your arms, hands, legs, or feet |[ ] [ ]  Difficulty fully moving your head side to side |
|  |[ ] [ ]  Back pain |[ ] [ ]  Difficulty squatting to the ground |
|  |[ ] [ ]  Difficulty fully moving your arms and legs |[ ] [ ]  Difficulty climbing a flight of stairs or a ladder |
|  |[ ] [ ]  Pain or stiffness when you lean forward or backward at the waist |[ ] [ ]  Difficulty carrying more than 25 pounds |
|  |[ ] [ ]  Difficulty fully moving your head up or down |[ ] [ ]  Any other muscle or skeletal problem that you think may interfere with using a respirator |

 **16**. Would you like to talk about your answers to this questionnaire with the healthcare professional who will be reviewing it? [ ] Yes [ ] No

Healthcare Professional Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_

Provider Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_

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