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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|  |  |  |  |
| --- | --- | --- | --- |
| **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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_

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

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