

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (MANDATORY)

(To Be Completed By the Employee)

Note 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. If the employee requires assistance with this questionnaire, please complete the following:

Employee Assisted By: _____ **Phone #:** _____

Note to the employee: Your employer must allow you to answer this questionnaire during normal working hours or at a time and place that is a convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers. 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) Employees selected to use any type of respirator must provide the following information:

Date:		Name:	
Age:		Sex : <input type="checkbox"/> Male <input type="checkbox"/> Female	
Height:	ft. in.	Weight:	lbs.
Job title:			
Phone number where you can be reached by the health care professional who reviews this questionnaire (include area code ())			
Best time to phone you at this number: ____AM ____PM			
Has your employer told you how to contact the health care professional who will review this questionnaire? <input type="checkbox"/> YES <input type="checkbox"/> NO			

NOTE: The information below is available from your employer.

Check the type of respirator(s) you will use (you can check more than one):	N, R, or P disposable respirator (filter-mask, non-cartridge) Half-face Full Face Powered air-purifying cartridge respirator (PAPR) Supplied Air respirator (SAR) Self-Contained Breathing Apparatus (SCBA) Other (specify)_____	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
What is the approximate weight of the respirator you'll be using?			
Describe the work you will be doing while wearing a respirator:			
Approximately how often will you being using the respirator?			
Approximately how long will you be wearing the respirator?			
What other personal protective equipment will you wear along with the respirator?			
Describe extremes in temperature and humidity you will experience when wearing the respirator.			

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

1. Do you <i>currently</i> smoke tobacco?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
a. Have you smoked in the last month?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Have you ever had any of the following conditions?		
a. Seizures?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Within the last two (2) years?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you currently under the care of MD for your seizures?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are your seizures under control?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Diabetes (sugar disease)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you currently under the care of MD for diabetes?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is your diabetes under control?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
How do you control your diabetes? ____ diet ____ exercise ____ injection ____ pill		
c. Allergic reactions that interfere with your breathing?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. Claustrophobia (fear of closed-in places)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Does wearing a respirator cause your claustrophobia?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e. Trouble smelling odors?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Have you ever had any of the following pulmonary or lung problems?		
a. Asbestosis?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Asthma?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Treated within the last two (2) years?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you currently taking any Asthma medication?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Chronic bronchitis?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. Emphysema?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e. Pneumonia?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you currently receiving treatment for pneumonia?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Has it been resolved?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
f. Tuberculosis?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you received treatment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Has it been resolved?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
g. Silicosis?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
h. Pneumothorax (collapsed lung)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you received treatment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Has it been resolved?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
i. Lung cancer?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
j. Broken ribs?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you received treatment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Has it been resolved?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
k. Any chest injuries or surgeries	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you received treatment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Has it been resolved?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
l. Any other lung problems that you are aware of?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

4. Do you currently have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Shortness of breath when walking with other people at an ordinary pace on level ground?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. Have to stop for breath when walking at your own pace on level ground?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e. Shortness of breath when washing or dressing yourself?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
f. Shortness of breath that interferes with your job?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
g. Coughing that produces phlegm (thick sputum)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
h. Coughing that wakes you early in the morning?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
i. Coughing that occurs mostly when you are lying down?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
j. Coughing up blood in the last month?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
k. Wheezing?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
l. Wheezing that interferes with your job?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
m. Chest pain when you breathe deeply?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
n. Any other symptoms that you think may be related to lung problems?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Have you ever had any of the following cardiovascular or heart problems?		
a. Heart attack?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, what was the date of your heart attack? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Stroke?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, has your MD medically cleared you to perform a job requiring a respirator?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Angina (chest pain)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. Heart failure?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e. Swelling in your legs or feet (not caused by walking)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
f. Heart arrhythmia (heart beating irregularly or very fast)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
g. High blood pressure?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you under the care of MD for high blood pressure?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is your blood pressure under control with medication?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
h. Any other heart problems that you are aware of?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Have you ever had any of the following cardiovascular or heart symptoms?		
a. Frequent pain or tightness in your chest?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Within the last two years?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Pain or tightness in your chest during physical activity?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Within the last two years?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Pain or tightness in your chest that interferes with your job?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Within the last two years?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. In the past two years, have you noticed your heart skipping or missing a beat?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you seen a MD for this condition?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Has your MD medically cleared you to perform a job requiring a respirator?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e. Heartburn or indigestion that is not related to eating?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Within the last two years?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
f. Any other symptoms that you think may be related to heart or circulation problems (describe):	<input type="checkbox"/> YES	<input type="checkbox"/> NO

7. Do you currently take medication for any of the following problems?		
a. Breathing or lung problems?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Heart trouble?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Blood pressure?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. Seizure (fits)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e. Diabetes (shot or pill)?	<input type="checkbox"/> YES	<input type="checkbox"/> 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 here ____ and go to question 9.		
a. Eye irritation when using a respirator?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Skin allergies or rashes when using a respirator?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Anxiety, choking or hyperventilation (over-breathing) while using a respirator?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. General weakness or fatigue when using a respirator?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e. Any other problem that interferes with your use of a respirator?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If you've used a respirator before, what kind(s)?		
9. Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p><u>READ CAREFULLY:</u> Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face 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. If questions 10-15 are not applicable and you do not wish to answer them voluntarily, please go to the last page of this questionnaire. Provide an explanation for any item in questions 1-9 for which you checked 'yes'. Whether or not you have any yes answers, you must sign the questionnaire at the end.</p>		
10. Have you ever lost vision in either eye? (temporarily or permanently)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
11. Do you currently have any of the following vision problems?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
a. Wear contact lenses?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Wear glasses	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Are you required to wear glasses while wearing a respirator?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. Color blind?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e. Any other eye or vision problem?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
12. Have you ever had an injury to your ears, including a broken ear drum?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is your ear drum currently ruptured?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
13. Do you currently have any of the following hearing problems?		
a. Difficulty hearing?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Wear a hearing aid?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Any other hearing or ear problem?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
14. Have you ever had a back injury?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
a. Does this currently make use of a respirator difficult?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

15. Do you currently have any of the following musculoskeletal problems?		
a. Weakness in any of your arms, hands, legs, or feet?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Back pain?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Difficulty fully moving your arms and legs?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. Pain or stiffness when you lean forward or backward at the waist?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e. Difficulty fully moving your head up or down?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
f. Difficulty fully moving your head side to side?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
g. Difficulty bending at your knees?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
h. Difficulty squatting to the ground?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
j. Any other muscles or skeletal problem that interferes with using a respirator?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

READ CAREFULLY: Please provide an explanation for any item in questions 1-15 for which you checked 'yes'. Whether or not you have any yes answers, you must sign the questionnaire at the end.

NOTE TO PROVIDERS: Any questions from Part B of this questionnaire (found at https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=standards&p_id=9783) and other questions not listed above can be asked at your discretion to make an informed decision in granting medical clearance for respirator use.

Please explain all 'yes' answers below.

Question Number	Explanation

The above answers have been supplied by me and are true to the best of my

Employee

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