OSHR Respirator Medical Evaluation Questionnaire (Mandatory)

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.

To the **employee**: 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 of respirator (please print).

Name: ______________________________ Job Title: ______________________________ Date: ____________

Age: ____________ Birth Sex: __________________ Height (ft – in.): _____________ Weight (lbs): _________

A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): ____________________________________

The best time to phone you at this number: ____

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

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-facepiece type, powered-air purifying, supplied-air, self- contained breathing apparatus).

Have you worn a respirator (circle one): Yes No

If "yes," what type(s): ____

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?:

Seizures	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?

Asbestosis:	Yes	No
Asthma:	Yes	No
Chronic bronchitis:	Yes	No
Emphysema:	Yes	No
Pneumonia:	Yes	No
Tuberculosis:	Yes	No
Silicosis:	Yes	No
Pneumothorax (collapsed lung):	Yes	No
Lung cancer:	Yes	No
Broken ribs:	Yes	No
Any chest injuries or surgeries:	Yes	No
Any other lung problem that you've been told about:	Yes	No

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

Shortness of breath:	Yes	No
Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	Yes	No
Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes	No
Have to stop for breath when walking at your own pace on level ground:	Yes	No
Shortness of breath when washing or dressing yourself:	Yes	No
Shortness of breath that interferes with your job:	Yes	No
Coughing that produces phlegm (thick sputum):	Yes	No
Coughing that wakes you early in the morning:	Yes	No
Coughing that occurs mostly when you are lying down:	Yes	No
Coughing up blood in the last month:	Yes	No
Wheezing:	Yes	No
Wheezing that interferes with your job:	Yes	No
Chest pain when you breathe deeply:	Yes	No
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?

Heart attack:	Yes	No
Stroke:	Yes	No
Angina:	Yes	No
Heart failure:	Yes	No
Swelling in your legs or feet (not caused by walking):	Yes	No

Heart arrhythmia (heart beating irregularly): Yes No

High blood pressure: Yes No

Any other heart problem that you've been told about: Yes No

6. Have you ever had any of the following cardiovascular or heart symptoms?

Frequent pain or tightness in your chest: Yes No

Pain or tightness in your chest during physical activity Yes No

Pain or tightness in your chest that interferes with your job: Yes No

In the past two years, have you noticed your heart skipping or missing a beat: Yes No

Heartburn or indigestion that is not related to eating: Yes No

Any other symptoms that you think may be related to heart or circulation problems: Yes No

7. Do you currently take medication for any of the following problems?

Breathing or lung problems: Yes No

Heart trouble: Yes No

Blood pressure: Yes No

Seizures: Yes 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 the following space and go to question 9:)

Eye irritation: Yes No

Skin allergies or rashes: Yes No

Anxiety: Yes No

General weakness or fatigue: Yes No

Any other problem that interferes with your use of a 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 to 15 below must be answered by every employee who has been selected to use either a **full-facepiece 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.

10. Have you ever lost vision in either eye (temporarily or permanently): Yes No

11. Do you currently have any of the following vision problems?

Wear contact lenses: Yes No

Wear glasses: Yes No

Color blind: Yes No

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?

Difficulty hearing:	Yes No
Wear a hearing aid:	Yes No
Any other hearing or ear problem:	Yes No

14. Have you ever had a back injury: Yes No

15. Do you currently have any of the following musculoskeletal problems?

Weakness in any of your arms, hands, legs, or feet:	Yes No
Back pain:	Yes No
Difficulty fully moving your arms and legs:	Yes No
Pain or stiffness when you lean forward or backward at the waist:	Yes No
Difficulty fully moving your head up or down:	Yes No
Difficulty fully moving your head side to side:	Yes No
Difficulty bending at your knees:	Yes No
Difficulty squatting to the ground:	Yes No
Climbing a flight of stairs or a ladder carrying more than 25 lbs:	Yes No
Any other muscle or skeletal problem that interferes with using a respirator:	Yes No

Part B. Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. 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

2. At work or at home, have you ever been exposed to hazardous solvents, airborne chemicals (gases, fumes, dust), or had skin contact with hazardous chemicals: Yes No

   If "yes," name the chemicals if you know them: ______________________________

   ____

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

Asbestos:	
	Yes No
Silica (e.g., in sandblasting):	Yes No
Tungsten/cobalt (e.g., grinding or welding this material):	Yes No
Beryllium:	Yes No

Aluminum: Yes No

Coal (for example, mining): Yes No

Iron: Yes No

Tin: Yes No

Dusty environments: Yes No

Any other hazardous exposures: Yes No

If "yes," describe these exposures: ____

____

____

4. List any second jobs or side businesses you have: ____

____

5. List your previous occupations: ____

____

6. List your current and previous hobbies: ____

____

7. 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

8. Have you ever worked on a HAZMAT team? Yes No

9. 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

   If "yes," name the medications if you know them: ____

10. Will you be using any of the following items with your respirator(s)?

    HEPA Filters: Yes No

    Canisters (for example, gas masks): Yes No

    Cartridges: Yes No

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

    Escape only (no rescue): Yes No

    Emergency rescue only: Yes No

    Less than 5 hours per week: Yes No

    Less than 2 hours per day: Yes No

    2 to 4 hours per day: Yes No

    Over 4 hours per day: Yes No

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

    Light (less than 200 kcal per hour): Yes No

    If "yes," how long does this period last during the average shift: ____hrs. ____mins.

    Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.

    Moderate (200 to 350 kcal per hour): Yes No

    If "yes," how long does this period last during the average shift:__hrs.____mins.

    Examples of moderate work effort 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.

    Heavy (above 350 kcal per hour): Yes No

    If "yes," how long does this period last during the average shift:__hrs.____mins.

    Examples of heavy work 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.).

13. 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:____

    ____

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

15. Will you be working under humid conditions: Yes No

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

    ____

    ____

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

    ____

    ____

18. 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: ____________________

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

    ____

19. 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): ____________________

    ____