

OSHA Respirator Medical Evaluation Questionnaire

Can you read (check one):     Yes      No

**The following information must be provided by every individual who has been selected to use any type of respirator (please print).**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Job Title: \_\_\_\_\_

Department: \_\_\_\_\_

Supervisor: \_\_\_\_\_

Social Security Number (for Health Services records only): \_\_\_\_\_

Date of Birth:: \_\_\_\_\_

Sex (check one):     Male      Female

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 (check 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-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Do you have any of the following conditions which could affect respirator fit?

- |   |  |
|---|--|
| <input type="checkbox"/> Clean Shaven   | <input type="checkbox"/> Facial Scar     |
| <input type="checkbox"/> 1-2 Day Growth | <input type="checkbox"/> Dentures Absent |
| <input type="checkbox"/> 2+ Day Growth  | <input type="checkbox"/> Glasses         |
| <input type="checkbox"/> Mustache       | <input type="checkbox"/> None            |

Comments: \_\_\_\_\_

Have you worn a respirator before? (check one):

Yes  No

If "Yes," what type(s): \_\_\_\_\_

The questions below must be answered by every individual who has been selected to use any type of respirator (please check "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?

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Seizures (fits)
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Diabetes (sugar disease)
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Allergic reactions that interfere with your breathing
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Claustrophobia (fear of closed-in places)
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Trouble smelling odors

3. Have you **ever had** any of the following pulmonary or lung problems?

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Asbestosis
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Asthma
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Chronic bronchitis
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Emphysema
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pneumonia
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tuberculosis
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Silicosis
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pneumothorax (collapsed lung)
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Lung cancer
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Broken ribs
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Any chest injuries or surgeries
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Any other lung problem that you've been told about

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

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Shortness of breath  |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Shortness of breath when walking fast on level ground or walking up a slight hill or incline |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Shortness of breath when walking with other people at an ordinary pace on level ground       |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Have to stop for breath when walking at your own pace on level ground                        |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Shortness of breath when washing or dressing yourself  |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Shortness of breath that interferes with your job  |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Coughing that produces phlegm (thick sputum)   |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Coughing that wakes you early in the morning   |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Coughing that occurs mostly when you are lying down  |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Coughing up blood in the last month  |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Wheezing   |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Wheezing that interferes with your job   |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Chest pain when you breathe deeply   |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any other symptoms that you think may be related to lung problems                            |

5. Have you **ever had** any of the following cardiovascular or heart problems?

- |                              |                             |   |
|------------------------------|-----------------------------|---|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Heart attack  |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Stroke  |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Angina  |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Heart failure   |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Swelling in your legs or feet (not caused by walking) |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Heart arrhythmia (heart beating irregularly)          |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | High blood pressure                                   |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any other heart problem that you've been told about   |

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

- |                              |                             |   |
|------------------------------|-----------------------------|---|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Frequent pain or tightness in your chest  |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Pain or tightness in your chest during physical activity                          |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Pain or tightness in your chest that interferes with your job                     |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | In the past two years, have you noticed your heart skipping or missing a beat     |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Heartburn or indigestion that is not related to eating                            |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any other symptoms that you think may be related to heart or circulation problems |

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

- |                              |                             |                            |
|------------------------------|-----------------------------|----------------------------|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Breathing or lung problems |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Heart trouble              |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Blood pressure             |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Seizures                   |

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) :

- |                              |                             |   |
|------------------------------|-----------------------------|---|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Eye irritation  |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Skin allergies or rashes  |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Anxiety   |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | General weakness or fatigue                                     |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any other problem that interferes with your use of a respirator |

Check here if you have never used a respirator.

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 individual who has been selected to use either a **full-face piece respirator or a self-contained breathing apparatus (SCBA)**. For individuals 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?

- |                              |                             |                                 |
|------------------------------|-----------------------------|---------------------------------|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Wear contact lenses             |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Wear glasses                    |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Color blind                     |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any other eye or vision problem |

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?

- |                              |                             |                                  |
|------------------------------|-----------------------------|----------------------------------|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Difficulty hearing               |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Wear a hearing aid               |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any other hearing or ear problem |

14. Have you **ever had** a back injury?

- |                              |                             |
|------------------------------|-----------------------------|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|------------------------------|-----------------------------|

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

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Weakness in any of your arms, hands, legs, or feet                           |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Back pain  |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Difficulty fully moving your arms and legs                                   |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Pain or stiffness when leaning forward/backward at the waist                 |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Difficulty fully moving your head up or down                                 |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Difficulty fully moving your head side to side                               |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Difficulty bending at your knees   |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Difficulty squatting to the ground   |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Climbing a flight of stairs or a ladder carrying 25 lbs +                    |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any other muscle or skeletal problem that interferes with using a respirator |