OSHA Respirator Medical Evaluation Questionnaire

MidMichigan Health

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:
Can you read? ☐ Yes ☐ No Company Name: _____

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

Name:		Date:	Age:
Sex:	Your height: _____ ft. _____ in.	Your weight: _____ lbs.	Your job title:
A phone number where you can be reached by the health care professional who reviews this questionnaire: (_____) _____			
The best time to phone you at this number _____ am/pm Date of Birth: _____			
Has your employer told you how to contact the healthcare professional who will review this questionnaire? ☐ Yes ☐ No			
Check the type of respirator you will use (you can check more than one mask): ☐ Dust mask (N-95) ☐ Half face ☐ Full Face ☐ Air powered purifying ☐ Supplied air ☐ SCBA (self contained breathing apparatus)			
Have you worn a respirator: ☐ Yes ☐ No If Yes, what type(s)?			

Part A Section 2 (mandatory)
Questions 1 through 8 below must be answered by every employee who has been selected to use any type of respirator

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 (fits): ☐ 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:		
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
Asbestosis: ☐ Yes ☐ No	Any chest injuries or surgeries: ☐ Yes ☐ No	Any other lung problem that you've been told about: ☐ Yes ☐ No

Occupational Health

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

a. Shortness of breath ☐ Yes ☐ No
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline ☐ Yes ☐ No
c. Shortness of breath when walking with other people at an ordinary pace on level ground ☐ Yes ☐ No
d. Have to stop for breath when walking at your own pace on level ground ☐ Yes ☐ No
e. Shortness of breath when washing or dressing yourself ☐ Yes ☐ No
f. Shortness of breath that interferes with your job ☐ Yes ☐ No
g. Coughing that produces phlegm (thick sputum) ☐ Yes ☐ No
h. Coughing that wakes you early in the morning ☐ Yes ☐ No
i. Coughing that occurs mostly when you are lying down ☐ Yes ☐ No
j. Coughing up blood in the last month ☐ Yes ☐ No
k. Wheezing ☐ Yes ☐ No
l. Wheezing that interferes with your job ☐ Yes ☐ No
m. Chest pain when you breathe deeply ☐ Yes ☐ No
n. Any other symptoms that you think maybe related to lung problems ☐ Yes ☐ No

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

Heart Attack: ☐ Yes ☐ No	Swelling in your legs or feet (not caused by walking): ☐ Yes ☐ No
Stroke: ☐ Yes ☐ No	Heart arrhythmia (heart beating irregularly): ☐ Yes ☐ No
Angina: ☐ Yes ☐ No	Heart failure: ☐ Yes ☐ No
High blood pressure:	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
Heartburn or indigestion that is not related to eating: ☐ 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

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 (fits): ☐ 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, go to Question 9).

Eye irritation: ☐ Yes ☐ No	Skin allergies or rashes: ☐ Yes ☐ No	General weakness or fatigue: ☐ Yes ☐ No
Anxiety: ☐ 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 the questionnaire: ☐ Yes ☐ No

Questions 10-15 below must be answered by every employee who has 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 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 tenses: ☐ Yes ☐ No	Wear glasses: ☐ Yes ☐ No
Color Blind: ☐ Yes ☐ No	Any other eye or vision problem: ☐ Yes ☐ No

12. Have you ever had any 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	Wearing 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? ☐ Yes ☐ No	
Weakness in any of your arms, bands, 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 and down: ☐ Yes ☐ No	Difficulty fully moving your head side to side: ☐ Yes ☐ No
Climbing a flight of stairs or a ladder carrying more than 25 lbs: ☐ Yes ☐ No	Difficulty squatting to the ground: ☐ Yes ☐ No
Difficulty bending at your knees: ☐ 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, hazardous airborne chemicals (e.g. gases, fumes or dust) or have you come into contact with hazardous chemicals: ☐ Yes ☐ No If yes, name the chemicals:		
3. Have you ever worked with any of the materials, or under any of the conditions listed below:		
Asbestos: ☐ Yes ☐ No	Beryllium: ☐ Yes ☐ No	Aluminum: ☐ Yes ☐ No
Iron: ☐ Yes ☐ No	Tin: ☐ Yes ☐ No	Dusty environments: ☐ Yes ☐ No
Silica (used in sandblasting): ☐ Yes ☐ No	Tungsten/cobalt (e.g. grinding or welding this material): ☐ Yes ☐ No	
Coal (for example, mining): ☐ Yes ☐ No	Any other hazardous exposures: ☐ Yes ☐ No	
If "yes" describe those exposures:		
4. List any second jobs or side businesses you have:		
5. List any previous occupations:		
6. List your current and previous hobbies:		
7. Have you been in the military service? ☐ 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)?		
a. HEPA Filters: ☐ Yes ☐ No	b. Canisters: ☐ Yes ☐ No	c. 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	2-4 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?

a. **Light** (less than 200 kcal per hour): ☐ Yes ☐ No
If "yes" how long does this period last during the average shift: _____ hrs. _____min.
* Examples of a light work effort are sitting while writing, typing, drilling or performing light assembly work, or standing while operating a drill press (1.3 lbs) or controlling machines.

b. **Moderate** (200 to 350 kcal per hour): ☐ Yes ☐ No
If "yes" how long does this period last during the average shift: _____ hrs. _____min.
* 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 using a wheelbarrow with a heavy load (about 100 lbs) on a level surface.

c. **Heavy** (about 350 kcal per hour): ☐ Yes ☐ No
If "yes" how long does this period last during the average shift: _____ hrs. _____min.
* 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 degrees 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 lever per shift:	Duration of exposure per shift:
Name of third toxic substance:	Estimated maximum exposure level per shift:	Duration of exposure per shift:

The name of any other toxic substance 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)

Time:_____Date: _____Employee Signature: _____

Time:_____Date: _____Witness Signature: _____