OSHA Respirator Medical Evaluation Questionnaire

This form must be filled out **completely** and returned to the EHS Office for confidential review by a health care professional. Put the completed form in a sealed envelope. Write your name on the outside of the envelope along with "Respirator Medical Questionnaire". If the health care professional deems it necessary for a follow up medical examination – you will be contacted directly.

Section 1 , Section 2 and page 4 are required to be filled out by all employees.
Only employees wearing full face respirators or a self-contained breathing apparatus (SCBA) must fill out Section 3.

SECTION 1 **Today's Date**: _____

Name: _____

Age: _____ Gender: _____ Height: ____ ft ____ in Weight: _____ lbs

Job title: _____

Department: _____

Phone number you can be reached at: _____ Best Time(s): _____

Type of respirator to be used: _____

Have you ever worn a respirator? [ ] Yes [ ] No

If so, what type: _____

Duration and frequency of use: _____

Expected physical work effort during use of the respirator: _____

Other protective equipment or clothing to be worn: _____

Temperature or humidity extremes that may be encountered during respirator use? _____

Do you apply pesticides, insecticides, and or fertilizers? [ ] Yes [ ] No

SECTION 2

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?:

	Yes	**No**		**Yes**	**No**
Seizures or fits			Tuberculosis		
Diabetes (sugar disease)			Silicosis		
Allergic reactions that interfere with your breathing			Collapsed Lung		
Claustrophobia (fear of being in an enclosed space)			Lung Cancer		
Trouble smelling odors			Broken Ribs		
Asbestosis			Chronic bronchitis		
Asthma			Any chest injuries or surgeries		
Emphysema			Any other lung problem you've been told about		
Pneumonia					

3. Do you **currently** have any of the following?

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

4. Have you **ever had** any of the following?

	Yes	No		Yes	No
Heart Attack			Cardiovascular or heart symptoms?		
Stroke			Frequent pain or tightness in your chest		
Angina			Pain or tightness in your chest during physical activity		
Heart Failure			Pain or tightness in your chest that interferes with your job		
Swelling in your legs or feet (not caused by walking)			In the past 2 years, noticed your heart skip or miss a beat		
Heart arrhythmia (heart beating irregularly)			Heartburn or indigestion not related to eating		
High blood pressure			Any other symptoms you think may be related to heart or circulation problems		
Any other heart problem you've been told about					

6. Do you **currently** take medication for any of the following problems? Check all that apply.

[ ] Breathing or lung problems [ ] Blood pressure [ ] Not applicable

[ ] Heart trouble [ ] Seizures

7. If you've used a respirator, have you ever had any of the following problems?

[ ] Skin allergies or rashes [ ] Any other problem _____

[ ] General weakness or fatigue [ ] Not applicable

[ ] Anxiety

8. Would you like to talk to a health care professional about your answers to this questionnaire?

[ ] Yes [ ] No

SECTION 3 – For Full Face Respirator or SCBA Users Only

1. 1. Have you **ever** lost vision in either eye – temporarily or permanently? [ ] Yes [ ] No

2. Do you **currently** have any of the following vision problems:

[ ] wear contact lenses [ ] wear glasses [ ] color blind

[ ] other eye or vision problem [ ] not applicable

3. Have you **ever** had an injury to your ears, including a broken ear drum? [ ] Yes [ ] No

4. Do you **currently** have any of the following hearing problems:

[ ] difficult hearing [ ] any other hearing or ear problem

[ ] wear a hearing aid [ ] not applicable

5. Have you **ever** had a back injury? [ ] Yes [ ] No

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

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

Thank you.

VERIFICATION/CONSENT STATEMENT

I verify that the information provided in this medical history is true and complete to the best of my knowledge. I understand that this evaluation is designed to satisfy regulatory requirements and should not be considered to be a routine medical examination. Further, I agree to self report to my supervisor changes in my medical condition that might affect my ability to work safely in a respirator.

_____	_____	_____
Full name (printed)	Signature	Date

Reviewed by:

_____	_____	_____
Full name (printed)	Signature	Date

Employee needs a physical examination: *circle one* Yes No

Final Determination:

___ Employee is medically qualified to wear a respirator – unlimited use.

___ Employee is medically qualified to wear a respirator with the following restrictions:

_____

___ Employee is not medically qualified to wear a respirator.