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

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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

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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): ____________________________

________________________________________________________________________