RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Name_____ Date_____

Address_____ City_____ State_____ ZIP_____ Home/Cell Phone_____

Job Title_____ Shift_____ Work Department/Area_____ DOB_____

The following questions are taken verbatim from the <u>mandatory</u> Appendix C of OSHA standard 29 CFR 1910.134.

To the employee: Can you read? (Circle one) YES NO

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).

1. Today's Date					
2. Your age (to nearest yr)					
3. Sex	Male Female	Male Female	Male Female	Male Female	Male Female
4. Your height:	ft. in.	ft. in.	ft. in.	ft. in.	ft. in.
5. Your weight:	lbs.	lbs.	lbs.	lbs.	lbs.
6. A phone number where you can be reached by the health care professional who reviews this questionnaire. (include the area code).					
7. The best time to phone you at this number					
8. Has your employer ever told you how to contact the health care professional who will review this questionnaire	Yes No	Yes No	Yes No	Yes No	Yes No
9. Check the type of respirator you will use (you can check more than one category)					
a. N,R, or P disposable respirator (filter-mask, non-cartridge type only)					
b. Other type (for example, half-or full face piece type, powered-air purifying, supplied-air purifying, supplied-air, self-contained breathing apparatus)					
10. Have you worn a respirator?	Yes No	Yes No	Yes No	Yes No	Yes No
If yes, what type(s)					

Respirator Medical Evaluation Questionnaire

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 check "yes" or "no").

DATE

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?														
2. Have you ever had any of the following conditions?														
a. Seizures (fits):														
b. Diabetes (sugar disease):														
c. Allergic reactions that interfere with your breathing:														
d. Claustrophobia (fear of closed-in places):														
e. Trouble smelling odors:														
3. Have you ever had any of the following pulmonary or lung problems:														
a. Asbestosis (lung disease from asbestos):														
b. Asthma														
c. Chronic bronchitis														
d. Emphysema														
e. Pneumonia														
f. Tuberculosis														
g. Silicosis (sand blasters disease)														
h. Pneumothorax (collapsed lung)														
i. Lung cancer														
j. Broken ribs														
k. Any chest injuries or surgeries														
l. 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?														
a. Shortness of breath														
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline														
c. Shortness of breath when walking with other people at an ordinary pace on level ground														
d. Have to stop for breath when walking at your own pace on level ground														
e. Shortness of breath when washing or dressing yourself														
f. Shortness of breath that interferes with your job														
g. Coughing that produces phlegm (thick sputum)														
h. Coughing that wakes you early in the morning:														
i. Coughing that occurs mostly when you are lying down:														
j. Cough up blood in the last month														
k. Wheezing														
l. Wheezing that interferes with your job														

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
m. Chest pain when you breathe deeply														
n. Any other symptoms that you think may be related to lung problems														
	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
5. Have you ever had any of the following cardiovascular or heart problem?														
a. Heart attack:														
b. Stroke:														
c. Angina (chest pain):														
d. Heart failure:														
e. Swelling in your legs or feet (not caused by walking):														
f. Heart dysrhythmia (heart beating irregularly):														
g. High blood pressure:														
h. Any other heart problem that you've been told about?														
6. Have you ever had any of the following cardiovascular or heart symptoms?														
a. Frequent pain or tightness in your chest:														
b. Pain or tightness in your chest during physical activity:														
c. Pain or tightness in your chest that interferes with your job:														
d. In the past two years, have you noticed your heart skipping or missing a beat:														
e. Heart burn or indigestion that is not related to eating:														
f. 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?														
a. Breathing or lung problems:														
b. Heart trouble:														
c. Blood pressure:														
d. Seizures (fits):														
8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, mark N/A in the following space and go to question 9).														
a. Eye irrtation:														
b. Skin allergies or rashes:														
c. Anxiety:														
d. General weakness or fatigue:														
e. Any other problem that interferes with your use of a respirator:														
9. Would you like to talk to the health care professional that will review this questionnaire about your answers to the questionnaire?														

Questions 10 to 15 below must be answered by every employee, who has been selected to use either a full-faced 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.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
10. Have you ever lost vision in either eye (temporarily or permanently)														
11. Do you currently have any of the following vision problems?														
a. Wear contact lenses:														
b. Wear glasses:														
c. Color blind:														
d. Any other eye or vision problem:														
12. Have you had an injury to your ears, including a broken eardrum?														
13. Do you currently have any other of the following hearing problems?														
a. Difficulty hearing:														
b. Wear a hearing aid:														
c. Any other hearing or ear problems:														
14. Have you ever had a back injury?														
15. Do you currently have any of the following musculoskeletal problems?														
a. Weakness in any of your arms, hands, legs, or feet:														
b. Back pain:														
c. Difficulty fully moving your arms or legs:														
d. Pain or stiffness when you lean forward or backward at the waist:														
e. Difficulty fully moving your head up or down:														
f. Difficulty fully moving your head from side to side:														
g. Difficulty bending at your knees:														
h. Difficulty squatting to the ground:														
i. Difficulty climbing a flight of stairs or ladder carrying more than 25 lbs:														
j. Any other muscle or skeletal problem that interferes with using a respirator:														

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.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
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?														
If "yes" do you have feelings of dizziness, shortness of breath, pounding in the chest, or other symptoms when you're working under these conditions?														
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 skin contact with hazardous chemicals?														
If "yes" name the chemicals if you know them:														
	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
3. Have you worked with any of the materials, or under any of the conditions, listed below?														
a. Asbestos:														
b. Silica (e.g., in sand blasting):														
c. Tungsten/cobalt (e.g., grinding or welding this material):														
d. Beryllium:														
e. Aluminum:														
f. Coal (for example, mining):														
g. Iron:														
h. Tin:														
i. Dusty environments:														
j. Any other hazardous exposures:														
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:														
	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
7. Have you been in the military services?														
If "yes" were you exposed to biological or chemical agents (either in training or combat):														
8. Have you ever worked on a HAZMAT team?														

	Yes	No		Yes	No		Yes	No		Yes	No		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 reasons (including over-the-counter medications)?														
10. Will you be using any of the following items with your respirator(s)?														
a. HEPA filter:														
b. Canisters (for example, gas masks):														
c. Cartridges:														
11. How often are you expected to use the respirator (s)? (Check "yes" or "no" for all answers that apply to you):														
a. Escape only (no rescue)														
b. Emergency rescue only:														
c. Less than 5 hours per week:														
d. Less than 2 hours per day:														
e. 2 to 4 hours per day:														
f. Over 4 hours per day:														
12. During the period you are using the respirator (s), is your work effort:														
a. Light (less than 200 kcal per hour): 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. Yes/No If "yes" how long does this period last during the average shift?	Yes Hrs.	No Mins.		Yes Hrs.	No Mins.		Yes Hrs.	No Mins.		Yes Hrs.	No Mins.		Yes Hrs.	No Mins.
b. Moderate (200 to 350 kcal per hour): Examples of moderate work effort are sitting while nailing of filing: driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35lbs.) 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. Yes/No If "yes" how long does this period last during the average shift?	Yes Hrs.	No Mins.		Yes Hrs.	No Mins.		Yes Hrs.	No Mins.		Yes Hrs.	No Mins.		Yes Hrs.	No Mins.
c. Heavy (above 350kcal per hour): 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 casting; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50lbs.) Yes/No If "yes" how long does this period last during the average shift?	Yes Hrs.	No Mins.		Yes Hrs.	No Mins.		Yes Hrs.	No Mins		Yes Hrs.	No Min.		Yes Hrs.	No Mins.

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator? Yes/No If "yes" how long does this period last during the average shift?	Yes Hrs.	No Mins.		Yes Hrs.	No Mins.		Yes Hrs.	No Mins.		Yes Hrs.	No Mins.		Yes Hrs.	No Mins.
	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
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:	Hrs.		Mins.											
Name of second toxic substance:														
Estimated maximum exposure level per shift:														
Duration of exposure per shift:	Hrs.		Mins.											
Name of third toxic substance:														
Estimated maximum exposure level per shift:														
Duration of exposure per shift:	Hrs.		Mins.											
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):														

Date _____ Patient Signature _____

Date _____ Patient Signature _____

Date _____ Patient Signature _____

Date _____ Patient Signature _____

Date _____ Patient Signature _____