

## OSHA Respirator Medical Evaluation Questionnaire — Mandatory

**To the employer:** Answers to questions in Section 1 to question 9 in Section 2 of Part A, does not require a medical examination.

**To the employee:** Can you read:  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 name: \_\_\_\_\_
3. Your age (to nearest year): \_\_\_\_\_
4. Sex:  Male  Female
5. Your height: \_\_\_\_\_
6. Your weight: \_\_\_\_\_
7. Your job title: \_\_\_\_\_
8. Phone (Enter a number where you can be reached by the healthcare professional who reviews this questionnaire.) \_\_\_\_\_
9. Best time to call: \_\_\_\_\_
10. Has your employer told you how to contact the health care professional who will review this questionnaire?  Yes  No
11. 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 (example, half or full face piece type, powered air purifying, supplied air, self contained breathing apparatus).
12. Have you worn a respirator?  Yes  No If yes, what type(s): \_\_\_\_\_

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#### Med Plus Pismo Beach

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#### Med Plus Central Coast

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**Part A. Section 2 (Mandatory)**

**Questions 1-9 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?
- 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                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Angina   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart failure                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Swelling your legs or feet (not caused by walking) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
6. Have you **ever had** any of the following cardiovascular or heart problems?
- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Heart arrhythmia (heart beating irregularly)        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High blood pressure                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any other heart problem that you've been told about | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
7. Do you **currently** take medication for any of the following problems?
- |                            |                              |                             |
|----------------------------|------------------------------|-----------------------------|
| Breathing or lung problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart trouble              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood pressure             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Seizures (fits)            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
8. If you have used a respirator, have you **ever had** any of the following problems?  
(If you've never used a respirator, skip this question and go on to the next question.)
- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Eye irritation  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Skin allergies or rashes  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anxiety   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| General weakness or fatigue                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any other problem that interferes with your use of a respirator | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
9. Would you like to talk to the health care professional that will review this 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 the 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             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Wear glasses                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Color blind                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any other eye or vision problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
12. Have you **ever had** an injury to your ears, including a broken eardrum?  Yes  No
13. Do you **currently** have any of the following hearing problems?
- |                                  |                              |                             |
|----------------------------------|------------------------------|-----------------------------|
| Difficulty hearing               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Wear a hearing aid               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any other hearing or ear problem | <input type="checkbox"/> Yes | <input type="checkbox"/> 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                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Back pain  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty fully moving your arms and legs                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pain or stiffness when you lean forward or backward at the waist             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty fully moving your head up or down                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty fully moving your head side to side                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty bending at your knees   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty squatting to the ground   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Climbing a flight of stairs or a ladder carrying more than 25 lbs.           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any other muscle or skeletal problem that interferes with using a respirator | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

## Part B. Section 2

**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.**

- In your present job, are you working at high altitudes (over 5,000') 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 your chest, or other symptoms when you're working under these conditions?  Yes  No
- 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 if you know them: \_\_\_\_\_
- 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) 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: \_\_\_\_\_
- List any second jobs or side businesses you have: \_\_\_\_\_
- List your previous occupation: \_\_\_\_\_
- List your current and previous hobbies: \_\_\_\_\_
- 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
- 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)?  Yes  No  
 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) (check 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
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: \_\_\_\_\_ hours \_\_\_\_\_ minutes  
 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: \_\_\_\_\_ hours \_\_\_\_\_ minutes  
 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° grade about 3 mph; or **pushing** a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.  
**High** (above 350 kcal per hour)  Yes  No  
 If yes, how long does this period last during the average shift: \_\_\_\_\_ hours \_\_\_\_\_ minutes  
 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° 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°F)?  Yes  No
15. Will you be working under humid conditions?  Yes  No
16. Describe the work you'll be doing while using your equipment: \_\_\_\_\_

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): \_\_\_\_\_  
\_\_\_\_\_