Dignity Health.
Pacific Central Coast Health Centers
Med Plus

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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71888-13 (4/19) OSHA / 6 pages / 2 sided

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	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Angina	☐ Yes	☐ No
Heart failure	☐ Yes	☐ No
Swelling your legs or feet (not caused by walking)	☐ Yes	☐ No

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

Heart arrhythmia (heart beating irregularly)	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Any other heart problem that you've been told about	☐ 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 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	☐ 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 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 or 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 eardrum? ☐ 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. 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.

1. 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

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 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) 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 occupation:_____

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)? ☐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 5º 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 8º 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 77ºF)? ☐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):_____

_____