OCCUPATIONAL SAFETY

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STOP! CONFIDENTIAL PATIENT INFORMATION!
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OSHA Respirator Medical Evaluation Questionnaire

The following information must be provided by every employee who has been selected to use any type of respirator (please print)

Date____________ Name _________________________ Employer ________________________

Sex ______ Height ____ft. ____in. Weight ______lbs Age ____ Date of Birth ____/____/____

Phone ___________________ best time to call_____________________ I.D. ______________

The following information must be provided by every employee who has been selected to use any type of respirator,

Indicate the type of respirator you will use (you may check more than one category)

☐ N, R, or P disposable respirator (filtering face piece, non-cartridge type only).
☐ Other type (for example, half or full-face, powered air purifying, supplied-air, SCBA)

Have you ever worn a respirator? .... ☐Yes ☐No
Has your employer told you how to contact us, if necessary? .... ☐Yes ☐No
Can you read English? .... ☐Yes ☐No

Section I OSHA Medical Questionnaire

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?
   a. Seizures (fits).......... ☐Yes ☐No
   b. Diabetes (sugar disease).......... ☐Yes ☐No
   c. Allergic reactions that interfere with your breathing (Hay fever).......... ☐Yes ☐No
   d. Claustrophobia (fear of closed-in –places).......... ☐Yes ☐No
   e. Trouble smelling odors.......... ☐Yes ☐No

3. Have you ever had any of the following pulmonary or lung problems?
   a. Asbestosis.......... ☐Yes ☐No
   b. Asthma.......... ☐Yes ☐No
   c. Chronic bronchitis.......... ☐Yes ☐No
   d. Emphysema.......... ☐Yes ☐No
   e. Pneumonia.......... ☐Yes ☐No
   f. Tuberculosis .... ☐Yes ☐No
   g. Silicosis .... ☐Yes ☐No
   h. Pneumothorax (collapsed lung).......... ☐Yes ☐No
   i. Lung cancer.......... ☐Yes ☐No
   j. Broken ribs.......... ☐Yes ☐No
   k. Any Chest injuries or surgeries.......... ☐Yes ☐No
   l. Any other lung problem that you have been told about.......... ☐Yes ☐No

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath……………………………………………………………………….. ☐Yes ☐No
   b. Shortness of breath when walking fast on level ground of walking up a slight hill or incline… ☐Yes ☐No
   c. Shortness of breath when walking with other people at an ordinary pace on level ground…… ☐Yes ☐No
   d. Have to stop for breath when walking at your own pace on level ground…………………….. ☐Yes ☐No
   e. Shortness of breath when washing or dressing yourself……………………………………….. ☐Yes ☐No
   f. Shortness of breath that interferes with your job………………………………………………. ☐Yes ☐No
   g. Coughing that produces phlegm (thick sputum)……………………………………………….. ☐Yes ☐No
   h. Coughing that wakes you early in the morning………………………………………………... ☐Yes ☐No
   i. Coughing that occurs mostly when you are lying down………………………………………. ☐Yes ☐No
   j. Coughing up blood in the last month………………………………………………………….. ☐Yes ☐No
   k. Wheezing ……………………………………………………………………………………… ☐Yes ☐No
   l. Wheezing that interferes with your job………………………………………………………... ☐Yes ☐No
   m. Chest pain when you breathe deeply…………………………………………………………... ☐Yes ☐No
   n. 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?
   a. Heart attack…………………………………………………………………………………….. ☐Yes ☐No
   b. Stroke…………………………………………………………………………………………... ☐Yes ☐No
   c. Angina………………………………………………………………………………………….. ☐Yes ☐No
   d. Heart failure……………………………………………………………………………………. ☐Yes ☐No
   e. Swelling in your hands or feet (not caused by walking)………………………………………. ☐Yes ☐No
   f. Heart arrhythmia (heart beating irregularly)……………………………………………………. ☐Yes ☐No
   g. High blood pressure……………………………………………………………………………. ☐Yes ☐No
   h. Any other heart problems that you have been told about……………………………………… ☐Yes ☐No

6. Have you ever had any of the following cardiovascular or heart symptoms?
   a. Frequent pain or tightness in your chest……………………………………………………….. ☐Yes ☐No
   b. Pain or tightness in your chest during physical activity……………………………………….. ☐Yes ☐No
   c. Pain or tightness in your chest that interferes with your job…………………………………... ☐Yes ☐No
   d. In the past two years, have you noticed your heart skipping or missing a beat………………. ☐Yes ☐No
   e. Heartburn not related eating …………………………………………………………………... ☐Yes ☐No
   f. 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?
   a. Breathing or lung problems……………………………………………………………………. ☐Yes ☐No
   b. Heart trouble…………………………………………………………………………………… ☐Yes ☐No
   c. Blood pressure…………………………………………………………………………………. ☐Yes ☐No
   d. Seizures (fits)…………………………………………………………………………………... ☐Yes ☐No

8. If you have used a respirator, has it caused any of the following problems?

   Is this your first time wearing a respirator? ………… ………………………………………….. ☐Yes ☐No
   a. Eye irritation…………………………………………………………………………………… ☐Yes ☐No
   b. Skin allergies or rashes………………………………………………………………………… ☐Yes ☐No
   c. Anxiety…………………………………………………………………………………………. ☐Yes ☐No
   d. General weakness or fatigue…………………………………………………………………… ☐Yes ☐No

9. Would you like to talk to the health care professional who will review this questionnaire? .... ☐Yes ☐No

10. Have you ever lost vision in either eye (temporally or permanently)? .... ☐Yes ☐No

11. Do you currently have any of the following vision problems?
   a. Wear contact lenses……………………………………………………………………………. ☐Yes ☐No
   b. Wear glasses…………………………………………………………………………………… ☐Yes ☐No
   c. Color blind…………………………………………………………………………………….. ☐Yes ☐No
   d. Any other eye or vision problems……………………………………………………………… ☐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?
   a. Difficulty hearing ☐Yes ☐No
   b. Wear a hearing aid ☐Yes ☐No
   c. Any other hearing or ear problem ☐Yes ☐No

14. Have you had a back injury? ☐Yes ☐No

15. Do you currently have any of the following musculoskeletal problems?
   a. Weakness in any of your arms, hands, legs or feet ☐Yes ☐No
   b. Back pain ☐Yes ☐No
   c. Difficulty moving your arms and legs ☐Yes ☐No
   d. Pain or stiffness when you lean forward or backward at the waist ☐Yes ☐No
   e. Difficulty moving your head up or down ☐Yes ☐No
   f. Difficulty moving you head side to side ☐Yes ☐No
   g. Difficulty bending your knees ☐Yes ☐No
   h Difficulty squatting to the ground ☐Yes ☐No
   i. Difficulty climbing a ladder or flight of stairs carrying a 25 lbs. load ☐Yes ☐No
   j. Any other muscle or skeletal problems that interfere with your use of a respirator ☐Yes ☐No

Section II OSHA Questionnaire

1. Have you ever worked with any of the materials, or under any of the conditions, listed below?
   a. Asbestos ☐Yes ☐No
   b. Silica (e.g. as in sand blasting) ☐Yes ☐No
   c. Tungsten/cobalt (including grinding or welding this material) ☐Yes ☐No
   d. Beryllium ☐Yes ☐No
   e. Aluminum ☐Yes ☐No
   f. Coal (including mining) ☐Yes ☐No
   g. Iron ☐Yes ☐No
   h. Tin ☐Yes ☐No
   i. Dusty environments ☐Yes ☐No
   j. Describe any other hazardous exposures ______________________________

2. Have you ever worked on a HAZMAT team? ☐Yes ☐No

3. Will you be using any of the following items with you respirator(s)?
   a. HEPA filters ☐Yes ☐No
   b. Canisters (e.g. gas masks) ☐Yes ☐No
   c. Cartridges ☐Yes ☐No

4. How often are you expected to use the respirator(s)? (Mark all answers that apply to you)
   a. Escape only (no rescue) ☐Yes ☐No
   b. Emergency (rescue only) ☐Yes ☐No
   c. Less than 5 hours per week ☐Yes ☐No
   d. Less than 2 hours per day ☐Yes ☐No
   e. 2 to 4 hours per day ☐Yes ☐No
   f. Over 4 hours per day ☐Yes ☐No

5. Will you be wearing protective clothing and /or equipment (other than the respirator) when you are using your respirator? If "yes" describe this protective clothing and/or equipment

____

6. Will you be working under hot conditions exceeding 77 degrees F?.. ☐Yes ☐No
7. Will you be working under humid conditions? .... ☐Yes ☐No
8. Describe the type of work you will be doing while using your respirator(s).

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9. Describe your level of work effort while using your respirator(s)?.............................. ☐ Heavy ☐ Medium ☐ Light
10. Describe any special; or hazardous conditions you might encounter when you are using your respirator(s) (for example, confined spaces, life-threatening gases)

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I certify the above statements are true to the best of my knowledge.

Employee Signature: ______________________________________ Date_______________

Stop Here! The remainder to be filled out by the Occupational Safety Technician.

Section III Spirometry Prescreen Questions:

YES NO 1. In the last 6 weeks have you had major surgery or been hospitalized?

YES NO 2. Within the last hour have you smoked tobacco?

YES NO 3. Have you had a lung infection such as a chest cold in the last 3 weeks?

YES NO 4. Have you used an inhaled bronchodilator in the past 6 hours?

YES NO 5. Have you taken more than 16 oz. of a caffeinated beverage within the last 6 hours?

Please adjust any clothing that would keep you from taking a full deep breath.

Blood Pressure ____/____, ____/____, ____/____ Sat ☐ Stood ☐ , for test.

Technicians Signature_____________________________________ Date_______________