

Respirator Medical Evaluation Questionnaire

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: Can you read? (check 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) * Please Print

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

Name: _____	Age (to nearest year) _____	Date ____/____/____	Job _____
Title: _____	OPTIONAL: S.S.# _____ - _____ - _____		
Sex: <input type="radio"/> Male <input type="radio"/> Female	Height: _____ feet _____ inches	Weight: _____ lbs	
Phone #: () - _____	*Where you can be reached by the health care professional who reviews this.		
The best time to be reached at this #: _____ A.M. / P.M.			
Has your employer told you how to contact the health care professional who will review this. <input type="radio"/> Yes <input type="radio"/> No			
*Check the type of respirator you will use (You can check more than one category)			
a. <input type="radio"/> N, R, or P disposable respirator (filter-mask, non cartridge type only).			
b. <input type="radio"/> Other type (for example, half- or full-face piece type, powered-air purifying, supplied air, self-contained breathing apparatus).			
Have you worn a respirator? <input type="radio"/> Yes <input type="radio"/> 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 check (4) "Yes" or "No"**

1. Yes No 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. Yes No Seizures (fits)
- b. Yes No Diabetes (sugar disease)
- c. Yes No Allergic reactions that interfere with breathing
- d. Yes No Claustrophobia (fear of closed-in places)
- e. Yes No Trouble smelling odors

3. Have you ever had any of the following pulmonary or lung problems?

- a. Yes No Asbestosis
- b. Yes No Asthma
- c. Yes No Chronic bronchitis
- d. Yes No Emphysema
- e. Yes No Pneumonia
- f. Yes No Tuberculosis
- g. Yes No Silicosis
- h. Yes No Pneumothorax (collapsed lung)
- i. Yes No Lung Cancer
- j. Yes No Broken Ribs
- k. Yes No Any chest injuries or surgeries
- l. Yes No 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. Yes No Shortness of breath
- b. Yes No Shortness of breath when walking fast on level ground or walking up a slight hill or incline

- c. Yes No Shortness of breath when walking with other people at an ordinary pace on level ground
- d. Yes No Have to stop for breath when walking at your own pace on level ground
- e. Yes No Shortness of breath when washing or dressing yourself
- f. Yes No Shortness of breath that interferes with your job
- g. Yes No Coughing that produces phlegm (thick sputum)
- h. Yes No Coughing that wakes you early in the morning
- i. Yes No Coughing that occurs mostly when you are laying down
- j. Yes No Coughing up blood in the last month
- k. Yes No Wheezing
- l. Yes No Wheezing that interferes with your job
- m. Yes No Chest pain when you breathe deeply
- n. Yes No Any other symptoms you think may be related to lung problems

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

- a. Yes No Heart attack
- b. Yes No Stroke
- c. Yes No Angina
- d. Yes No Heart failure
- e. Yes No Swelling in your legs or feet (not caused by walking)
- f. Yes No Heart arrhythmia (heart beating irregularly)
- g. Yes No High blood pressure
- h. Yes No Any other heart problem you've been told about

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

- a. Yes No Frequent pain or tightness in your chest
- b. Yes No Pain or tightness in your chest during physical activity
- c. Yes No Pain or tightness in your chest that interferes with your job
- d. Yes No In the past two years, have you noticed your heart skipping or missing a beat
- e. Yes No Heartburn or indigestion that is not related to eating
- f. Yes No 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. Yes No Breathing or lung problems
- b. Yes No Heart trouble
- c. Yes No Blood pressure
- d. Yes No 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 go to question 9)

- a. Yes No Eye irritation
- b. Yes No Skin allergies or rashes
- c. Yes No Anxiety
- d. Yes No General weakness or fatigue
- e. Yes No Other problems that interferes with your respirator use

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

*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. Yes No Have you ever lost vision in either eye (temporarily or permanently)?

11. Do you currently have any of the following vision problems?

- a. Yes No Wear contact lenses
- b. Yes No Wear glasses
- c. Yes No Color blind
- d. Yes No Other eye or vision problem

12. Yes No Have you ever had an injury to your ears, including a broken ear drum?

13. Do you currently have any of the following hearing problems?

- a. Yes No Difficulty Hearing
- b. Yes No Wear a hearing aid
- c. Yes No Any other hearing or ear problem

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

15. Do you currently have any of the following musculoskeletal problems?

- a. Yes No Weakness in any of your arms, hands, legs, or feet
- b. Yes No Back Pain
- c. Yes No Difficulty fully moving your arms and legs
- d. Yes No Pain or stiffness when you lean forward or backward at the waist
- e. Yes No Difficulty fully moving your head up or down
- f. Yes No Difficulty fully moving your head side to side
- g. Yes No Difficulty bending at your knees
- h. Yes No Difficulty squatting to the ground
- i. Yes No Climbing a flight of stairs or a ladder carrying more than 25 lbs.
- j. Yes No 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 this questionnaire.

1. Yes No 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

2. 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 skin contact with hazardous chemicals

*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:

- a. Yes No Asbestos
- b. Yes No Silica (e.g. in sandblasting)
- c. Yes No Tungsten / cobalt (e.g. grinding or welding this material)
- d. Yes No Beryllium
- e. Yes No Aluminum
- f. Yes No Coal (for example, mining)
- g. Yes No Iron
- h. Yes No Tin
- i. Yes No Dusty environments
- j. Yes No 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:

7. Yes No Have you been in the military service?

Yes No *If "Yes", were you exposed to biological or chemical agents (either in training or combat)

8. Yes No Have you ever worked on a hazmat team?

9. Yes No 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). *If "Yes", name the medications if you know them:

10. Will you be using any of the following items with your respirator(s)?

- a. Yes No HEPA Filters
- b. Yes No Canisters (for example, gas masks)
- c. Yes No Cartridges

11. How often are you expected to use the respirator(s)?

- a. Yes No Escape only (no rescue)
- b. Yes No Emergency rescue only
- c. Yes No Less than 5 hours per week
- d. Yes No Less than 2 hours per day
- e. Yes No 2 to 4 hours per day
- f. Yes No Over 4 hours per day

12. During the period you are using the respirator(s), is your work effort:

- a. Yes No **Light** (less than 200 kcal per hour)

*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.

- b. Yes No **Moderate** (200 to 350 kcal per hour)

*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.

- c. Yes No **Heavy** (above 350 kcal per hour)

*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. Yes No **Will you be wearing protective clothing and/or equipment** (other than the respirator) when you're using the respirator. *If "Yes", describe the protective clothing and/or equipment

14. Yes No **Will you be working under hot conditions** (temperature exceeding 77° F)

15. Yes No **Will you be working under humid conditions?**

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 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 **THIRD** toxic substance:

Estimated maximum exposure level per shift:

Duration of exposure per shift:

The name of **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):