Employer_____

Department of Occupational Medicine

OSHA Mandatory Medical Evaluation Questionnaire For Respirator Wearers

To the Employer: Answers to questions in Section I, and to question 9 in Section 2, of Part A, do not require a medical examination.

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 I, Mandatory

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

Today's Date:	Name:
Your age *(to the nearest year):*	Sex: *(circle one)* Male Female
Your height: feet inches	Your weight: lbs.
Your job title:	A phone number where you can be reached by the health care professional who reviews this questionnaire (include area code):
The best time to phone you at this number:	Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes No
Circle the type of respirator you will be using *(you can circle more than one category):* N. R. or P disposable respirator (filter-mask, non-cartridge type only) Other type (for example, half or full-facepiece type, powered-air purifying, supplied-air, self contained breathing apparatus).	Have you ever worn a respirator? (circle one) Yes No If yes, what type(s)?

PART A, Section 2, Mandatory

Questions 1 through 9 must be answered by every employee who has been selected to use any type of respirator (please check "yes" or "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?		
b. Asthma?		
c. Chronic bronchitis?		
d. Emphysema?		
e. Pneumonia?		
f. Tuberculosis?		
g. Silicosis?		
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 disease?		
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?		
f. Shortness of breath that interferes with your job?		
g. Coughing that produces phlegm (thick sputum)?		
h. Coughing that wakes you up early in the morning?		
i. Coughing that occurs mostly when you are lying down?		
j. Coughing up blood in the last month?		
k. Wheezing?		
l. Wheezing that interferes with your job?		
m. Chest pain when you breathe deeply?		
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?		
b. Stroke?		
c. Angina?		
d. Heart failure?		
e. Swelling in your legs or feet (not caused by walking)?		
f. Heart arrhythmia (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. Heartburn or indigestion that is not related to eating?		
f. Any other symptoms that you think might 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 *have* used a respirator, have you *ever had* any of the following problems? (If you have never used a respirator, check the following space and go to question 9).		
a. Eye irritation?		
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 who will review this questionnaire about your answers to this questionnaire?		

Questions 10 through 15 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.

	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 problems?		
12. 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. Difficulty hearing?		
b. Wearing a hearing aid?		
c. Any other hearing or ear problem?		
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 and 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 side to side?		
g. Difficulty bending your knees?		
h. Difficulty squatting to the ground?		
i. Climbing a flight of stairs or a ladder carrying more than 25 pounds?		
j. Any other muscle or skeletal problem that interferes with using a respirator?		

PART B

Employees - Answer the following questions *only if told to do so* when you received this questionnaire.

	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 your chest, or other symptoms when you're working under these conditions?		
2. At work or 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 material, or under any of the conditions listed below?		
a. Asbestos?		
b. Silica?		
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 may have:		
5. List your previous occupations:		
6. List your current and previous hobbies:		
7. Have you been in the military service?		
If yes, were you exposed to biological or chemical agents (either in training or in combat)?		

	YES	NO
8. Have you ever worked on a HAZMAT team?		
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)?		
If yes, name the medications if you know them:		
10. Will you be using any of the following with your respirator(s)?		
a. HEPA filters?		
b. Canisters (for example, gas masks)?		
c. Cartridges?		
11. How often are your expected to use the respirator(s)?		
a. Escape only (no rescue)?		
b. Emergency rescue only?		
c. Less than 5 hours *per week*?		
d. Less than 2 hours *per day*?		
e. 2-4 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)?		
If yes, how long does this period last during the average shift? hours minutes (Examples of light work effort are *sitting* while typing, drafting or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines.)		
b. Moderate (200-350 Kcal per hour)?		
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-degree grade about 3 mph; or *pushing* a wheelbarrow with a heavy load (about 100 lbs) on a level surface.)		
c. Heavy (above 350 Kcal per hour)?		
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-degree grade while 2mph; *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?		
If yes describe this protective clothing and/or equipment:		
14. Will you be working under hot conditions (temperatures exceeding 77 degrees F)?		
15. Will you be working under humid conditions?		

	YES	NO
16. Describe the work you'll be doing while you're wearing 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 toxic substance: Estimated maximum exposure level per shift: Duration of exposure per shift: Name of 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 any other toxic substances that you'll be exposed to while using your respirator(s).		
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):		

Name of Medical Professional evaluating questionnaire:

Address of Medical Professional evaluating form:

Telephone of Medical Professional evaluating form: