Twin Cities Occupational Health and Rehabilitation®

Back to work! Back to play! Back to life!

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Employer (Company) _____

Employee Name _____

Can you understand the writing on this page? (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 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 (circle one): Male / Female

5. Your height: _____ ft. _____ in.

6. Your weight: _____ lbs.

7. Your job title: _____

8. A phone number where you can be reached by the healthcare professional who reviews this questionnaire (include the Area Code): (_____)_____-_____

9. The best day-time hours to phone you at this number: _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes No

11. Check the type of respirator you will use (you can check more than one category):
   a. _____ N, R, or P disposable respirator (filter-mask, non- cartridge type only).
   b. _____ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): Yes No
   If "yes," what type(s):

Part A. Section 2. (Mandatory)

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 When_____Comments:_____
   b. Diabetes (sugar disease):
      Yes No
   c. Allergic reactions that interfere with your breathing:
      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 When_____Comments:_____
   b. Asthma:
      Yes No Current Treatment:_____
   c. Chronic bronchitis: When_____Comments: _____
      Yes No
   d. Emphysema:
      Yes No
   e. Pneumonia:
      Yes No When_____Comments:_____
   f. Tuberculosis:
      Yes No When_____Comments:_____
   g. Silicosis:
      Yes No
   h. Pneumothorax (collapsed lung):
      Yes No When_____Comments:_____
   i. Lung cancer:
      Yes No When_____Comments:_____
   j. Broken ribs:
      Yes No When_____Comments:_____
   k. Any chest injuries or surgeries:
      Yes No When_____Comments:_____
   l. Any other lung problem that you've been told about:
      Yes No When_____Surgery:_____
      Comments: _____

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 or walking up a slight hill/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 When_____Comments:_____
   b. Stroke:
      Yes No When_____Comments:_____
   c. Angina:
      Yes No
   d. Heart failure:
      Yes No
   e. Swelling in your legs 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 problem that you've 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 or indigestion that is not related to 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? Name of Medication.
   a. Breathing or lung problems:
      Yes No
   b. Heart trouble:
      Yes No
   c. Blood pressure:
      Yes No
   d. Seizures:
      Yes No

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9:)
   a. Eye irritation:
      Yes No
   b. Skin allergies or rashes:
      Yes No
   c. Anxiety:
      Yes No
   d. General weakness or fatigue:
      Yes No
   e. Any other problem that interferes with your use of a respirator:
      Yes No

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

Questions 10 to 15 below must be answered by <u>every employee who has been selected to use either a full-face piece 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.</u>

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?
    a. Wear contact lenses:
        Yes No
    b. Wear glasses:
        Yes No
    c. Color blind:
        Yes No
    d. Any other eye or vision problem:
        Yes No

12. Have you ever had an injury to your ears, including a broken eardrum:
        Yes No When:_____

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 ever had a back injury:
        Yes No When:_____

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 fully moving your arms and legs:
        Yes No
    d. Pain or stiffness when you lean forward or backward at the waist:
        Yes No
    e. Difficulty fully moving your head up or down:
        Yes No
    f. Difficulty fully moving your head side to side:
        Yes No
    g. Difficulty bending at your knees:
        Yes No
    h. Difficulty squatting to the ground:
        Yes No
    i. Climbing a flight of stairs or a ladder carrying more than 25 lbs:
        Yes No
    j. Any other muscle or skeletal problem that interferes with using a respirator:
        Yes No

Part B

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

6. List your current and previous hobbies:

7. Have you been in the military services?
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)?
a. HEPA Filters:
Yes No
b. Canisters (for example, gas masks):
Yes No
c. Cartridges:
Yes No

11. How often are you expected to use the respirator(s)? (Circle "yes" or "no" for 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

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

a. Light (Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a machine):

Yes No

If "yes," how long does this period last during the average shift:
_____hrs._____mins.

b. Moderate (Examples of a moderate work effort are sitting while nailing or filing, driving a motor vehicle in urban traffic, standing while drilling, nailing, performing assembly work, moving a 35 pound load at trunk level, walking on a level surfact or down a 5-degree grade, pushing a wheelbarrow with 100 pounds on a level surface.)

Yes No

If "yes," how long does this period last during the average shift:
_____hrs._____mins.

c. Heavy (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.)

Yes No

If "yes," how long does this period last during the average shift:
_____hrs._____mins.

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 deg. F):

Yes No

15. Will you be working under humid conditions:

Yes No

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 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 safety and well-being of others (for example, rescue, security):

Please turn in your completed form at your appointment or have it faxed to our clinics at:

South Metro Clinic
2520 Pilot Knob Road, Suite 250
Mendota Heights, MN 55120
FAX (651) 224-8265

North Metro Clinic
10190 Baltimore St. N.E., Suite 100
Blaine, MN 55449
FAX (763) 780-8274