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OSHA Respirator Medical Evaluation Questionnaire

Date:_____Name:_____Employee Number:_____

Height:_____ft._____in. Weight:_____lbs. Birth date:_____

Phone number where you can be reached by the health care professional who review this questionnaire: (_____)_____--_____

The best time to phone you at this number: AM PM

Has your employer told you how to contact the health care professional who will review this questionnaire: YES □ NO □

Check the type of respirator you will use (you can check more than one category):
a. _____N95 Disposable Respirator
b. _____Half Face Respirator
c._____Full Face Respirator
d._____Powered Air Purifying Respirator (PAPR)

Have you ever worn a respirator: YES □ NO □ If yes, what type(s): _____

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 illness?
		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 yourself
		f. Shortness of breath that interferes with your job
		g. Coughing that produces phlegm (thick sputum)
		h. Coughing that wakes you 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

Yes	No	
		n. Any other symptoms that you think may be related to lung problems
		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 may 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'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
		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 1 – 11 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.

Yes	No	
		1. Have you **ever** lost vision in either eye (temporarily or permanently)?
		2. 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 problem
		3. Have you **ever had** an injury to your ears, including a broken eardrum?
		4. Do you **currently** have any of the following hearing problems?
		a. Difficulty hearing
		b. Wear a hearing aid
		c. Any other hearing or ear problem
		5. Have you ever had a back injury
		6. 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 arm and legs
		d. Pain and 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 at your knees
		h. Difficulty squatting to the ground
		i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.
		j. Any other muscle or skeletal problem that interferes with using a respirator

Yes	No	
		7. How often are you expected to use the respirator(s)? Check yes or no for all answers that apply to you.
		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 to 4 hours **per** day
		f. Over 4 hours **per** day
		8. 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 the period last during the average shift: _____hrs. ___ mins.
		b. **Moderate** (200 to 350 kcal per hour) If yes, how long does the period last during the average shift: _____ hrs. ____ mins.
		c. **Heavy** (above 350 kcal per hour) If yes, how long does the period last during the average shift: _____hrs._____mins.
		9. Will you be wearing protective clothing and/or equipment (other than the respirator) If yes, describe the protective clothing and/or equipment _____
		10. Will you be working under hot conditions (temperature exceeding 77 degrees F?)
		11. Will you be working under humid conditions?

Describe the work you'll be doing while using your respirator (s):

_____

_____

_____

_____

Requestor's Signature:_____Date:_____

For UHS use only

Respirator type:_____(i.e. N95, full face, half face respirator, PAPR)

☐ Approved
☐ Approved with restrictions
☐ Denied

Restriction/Remarks:

_____

_____

University Health Clinician Signature:_____Date:_____