



- Ottawa
- Streator

Patient Name \_\_\_\_\_

MR # \_\_\_\_\_

DOB \_\_\_\_\_

**OSHA Respirator Medical Evaluation Questionnaire**



**OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE**

**Instructions:**

1. Complete the attached "OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE". **Part A, Section 1 and 2 are mandatory**
2. **Send all originals** to St Mary's Occupational Health, via mail or fax.
3. A licensed health care provider will review the questionnaire and forward recommendations to use a respirator to your employer. A physical exam may be required in response to this questionnaire.
4. St Mary's Occupational Health will contact you or your supervisor, when approval is received, to set up an appointment for fit testing.
5. St Mary's Occupational Health can be reached at Streator or Ottawa locations for any questions.

**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)** 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. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
4. Sex (check one): Male  Female
5. Your height: \_\_\_\_\_ ft. \_\_\_\_\_ in.
6. Your weight: \_\_\_\_\_ lbs.
7. Your job title: \_\_\_\_\_ Company Name: \_\_\_\_\_
8. A phone number where you can be reached by the health care professional who reviews this Questionnaire (include this Area Code): (\_\_\_\_\_) \_\_\_\_\_
9. The best time to phone you at this number: \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.
10. Has your employer told you how to contact the health care professional who will review this questionnaire (check 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-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator (check one):.....  Yes  No  
If "yes," what type(s): \_\_\_\_\_



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**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 "yes" or "no").

1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month: .....  Yes  No  
If yes how many years: \_\_\_\_\_

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: .....  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've 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 or 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



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- 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?**

- 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'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):.....  Never Used a Respirator**

- 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 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. 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
- e. Any other eye or vision problem:.....  Yes  No

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



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**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**

**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 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 the questionnaire.

**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: \_\_\_\_\_



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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) (check "yes" or "no" for all answers that apply to you)?:  
 a. Escape only (no rescue): .....  Yes  No  
 b. Less than 5 hours *per week*: .....  Yes  No  
 c. Less than 2 hours *per day*: .....  Yes  No  
 d. 2 to 4 hours *per day*: .....  Yes  No  
 e. Over 4 hours *per day*: .....  Yes  No

12. During the period you are using the respirator(s), is your work effort:  
 a. *Light* (less than 200 kcal per hour): .....  Yes  No  
 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. *Moderate* (200 to 350 kcal per hour): .....  Yes  No  
 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.



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

CHEMICAL/PRODUCT NAME	MAXIMUM EXPOSURE LEVEL	DURATION

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 well-being of others (for example, rescue, security): \_\_\_\_\_