OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (MANDATORY)

(To Be Completed By the Employee)

Note 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. If the employee requires assistance with this questionnaire, please complete the following:
Employee Assisted By:_____**Phone #:** _____

Note to the employee: Your employer must allow you to answer this questionnaire during normal working hours or at a time and place that is a convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers. 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) Employees selected to use any type of respirator must provide the following information:

Date:	**Name:**	
Age:	Sex : □ Male □ Female	
Height: ft. in.	Weight: lbs.	**J**ob title:
Phone number where you can be reached by the health care professional who reviews this questionnaire (include area code ( )		
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		

NOTE: The information below is available from your employer.

Check the type of respirator(s) you will use (you can check more than one):	N, R, or P disposable respirator (filter-mask, non-cartridge)	□ Yes	□ No
	Half-face	□ Yes	□ No
	Full Face	□ Yes	□ No
	Powered air-purifying cartridge respirator (PAPR)	□ Yes	□ No
	Supplied Air respirator (SAR)	□ Yes	□ No
	Self-Contained Breathing Apparatus (SCBA)	□ Yes	□ No
	Other (specify)_____	□ Yes	□ No
What is the approximate weight of the respirator you'll be using?			
Describe the work you will be doing while wearing a respirator:			
Approximately how often will you being using the respirator?			
Approximately how long will you be wearing the respirator?			
What other personal protective equipment will you wear along with the respirator?			
Describe extremes in temperature and humidity you will experience when wearing the respirator.			

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		
1. Do you *currently* smoke tobacco?	☐ YES	☐ NO
a. Have you smoked in the last month?	☐ YES	☐ NO
2. Have you ever had any of the following conditions?		
a. Seizures?	☐ YES	☐ NO
Within the last two (2) years?	☐ YES	☐ NO
Are you currently under the care of MD for your seizures?	☐ YES	☐ NO
Are your seizures under control?	☐ YES	☐ NO
b. Diabetes (sugar disease)?	☐ YES	☐ NO
Are you currently under the care of MD for diabetes?	☐ YES	☐ NO
Is your diabetes under control?	☐ YES	☐ NO
How do you control your diabetes? _____diet _____exercise _____injection _____pill		
c. Allergic reactions that interfere with your breathing?	☐ YES	☐ NO
d. Claustrophobia (fear of closed-in places)?	☐ YES	☐ NO
Does wearing a respirator cause your claustrophobia?	☐ 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
Treated within the last two (2) years?	☐ YES	☐ NO
Are you currently taking any Asthma medication?	☐ YES	☐ NO
c. Chronic bronchitis?	☐ YES	☐ NO
d. Emphysema?	☐ YES	☐ NO
e. Pneumonia?	☐ YES	☐ NO
Are you currently receiving treatment for pneumonia?	☐ YES	☐ NO
Has it been resolved?	☐ YES	☐ NO
f. Tuberculosis?	☐ YES	☐ NO
Have you received treatment?	☐ YES	☐ NO
Has it been resolved?	☐ YES	☐ NO
g. Silicosis?	☐ YES	☐ NO
h. Pneumothorax (collapsed lung)?	☐ YES	☐ NO
Have you received treatment?	☐ YES	☐ NO
Has it been resolved?	☐ YES	☐ NO
i. Lung cancer?	☐ YES	☐ NO
j. Broken ribs?	☐ YES	☐ NO
Have you received treatment?	☐ YES	☐ NO
Has it been resolved?	☐ YES	☐ NO
k. Any chest injuries or surgeries	☐ YES	☐ NO
Have you received treatment?	☐ YES	☐ NO
Has it been resolved?	☐ YES	☐ NO
l. Any other lung problems that you are aware of?	☐ 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
If yes, what was the date of your heart attack? _____	☐ YES	☐ NO
b. Stroke?	☐ YES	☐ NO
If yes, has your MD medically cleared you to perform a job requiring a respirator?	☐ YES	☐ NO
c. Angina (chest pain)?	☐ 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 or very fast)?	☐ YES	☐ NO
g. High blood pressure?	☐ YES	☐ NO
Are you under the care of MD for high blood pressure?	☐ YES	☐ NO
Is your blood pressure under control with medication?	☐ YES	☐ NO
h. Any other heart problems that you are aware of?	☐ 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
Within the last two years?	☐ YES	☐ NO
b. Pain or tightness in your chest during physical activity?	☐ YES	☐ NO
Within the last two years?	☐ YES	☐ NO
c. Pain or tightness in your chest that interferes with your job?	☐ YES	☐ NO
Within the last two years?	☐ YES	☐ NO
d. In the past two years, have you noticed your heart skipping or missing a beat?	☐ YES	☐ NO
Have you seen a MD for this condition?	☐ YES	☐ NO
Has your MD medically cleared you to perform a job requiring a respirator?	☐ YES	☐ NO
e. Heartburn or indigestion that is not related to eating?	☐ YES	☐ NO
Within the last two years?	☐ YES	☐ NO
f. Any other symptoms that you think may be related to heart or circulation problems (describe):	☐ 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. Seizure (fits)?	☐ YES	☐ NO
e. Diabetes (shot or pill)?	☐ 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 here ____ and go to question 9.		
a. Eye irritation when using a respirator?	☐ YES	☐ NO
b. Skin allergies or rashes when using a respirator?	☐ YES	☐ NO
c. Anxiety, choking or hyperventilation (over-breathing) while using a respirator?	☐ YES	☐ NO
d. General weakness or fatigue when using a respirator?	☐ YES	☐ NO
e. Any other problem that interferes with your use of a respirator?	☐ YES	☐ NO
If you've used a respirator before, what kind(s)?		
9. Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire?	☐ YES	☐ NO

READ CAREFULLY: Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face 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. If questions 10-15 are not applicable and you do not wish to answer them voluntarily, please go to the last page of this questionnaire. Provide an explanation for any item in questions 1-9 for which you checked 'yes'. Whether or not you have any yes answers, you must sign the questionnaire at the end.

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?	☐ YES	☐ NO
a. Wear contact lenses?	☐ YES	☐ NO
b. Wear glasses	☐ YES	☐ NO
c. Are you required to wear glasses while wearing a respirator?	☐ YES	☐ NO
d. 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 ear drum?	☐ YES	☐ NO
Is your ear drum currently ruptured?	☐ YES	☐ NO
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
a. Does this currently make use of a respirator difficult?	☐ 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 fulling 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 muscles or skeletal problem that interferes with using a respirator?	☐ YES	☐ NO

READ CAREFULLY: Please provide an explanation for any item in questions 1-15 for which you checked 'yes'. Whether or not you have any yes answers, you must sign the questionnaire at the end.

NOTE TO PROVIDERS: Any questions from Part B of this questionnaire (found at https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=standards&p_id=9783) and other questions not listed above can be asked at your discretion to make an informed decision in granting medical clearance for respirator use.

Please explain all 'yes' answers below.

Question Number	Explanation

The above answers have been supplied by me and are true to the best of my

_____ _____

Employee **Dat**