McMinnville Immediate Health Care &
OCCUPATIONAL MEDICINE

Respirator Medical Evaluation Questionnaire

EMPLOYER:

Note to Employer: On Jan. 8, 1998, OSHA published its revised Respiratory Protection Standard (29CFR 1910.134). Each employee must be medically evaluated prior to fit testing and the initial use of a respirator. OSHA requires employers to select a physician or other licensed health care professional to conduct the medical evaluation. Employees may be evaluated via a "hands-on" physical exam or via screening questionnaire. The screening questionnaire must be administered confidentially (employers are not allowed to see the answers to questions) and at a time and place that is convenient to the employee. OSHA also requires employers to get written recommendations from the physician or other licensed health care professional on whether an employee is medically able to use a respirator.

Note: If your employees have been medically evaluated since April 8, 1997 you may use the results of that evaluation, provided it meets OSHA's new requirements.

This questionnaire includes the mandatory questions required by OSHA for employees who will be using any type of respirator. If an employee answers yes to any question in Section 2 except the last question, a follow-up physical exam is required.

Section 3 of this questionnaire includes additional mandatory questions required for employees using full-facepiece respirators or SCBAs.

Company: _____

Part A. Section 1

1. Today's date _____

2. Your name _____

3. Address_____

_____

4. Age _____ Date of Birth _____

5. Gender (circle one) **Male Female**

6. Your height _____ ft. _____ in.

7. Your weight _____ lbs.

8. Your job title: _____

9. Telephone number where you can be reached by the healthcare professional who reviews this questionnaire (include area code)

_____

10. Have you been told by your employer how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No

_____

11. Check off each type of respirator you will using. ***(Ask your supervisor if you are uncertain..)***

☐ N, R, or P disposable respirator (filtering facepiece mask, non-cartridge type only)

☐ Other type (such as half or full- facepiece, powered air-purifying, or self-contained breathing apparatus)

Have you ever worn a respirator? ☐ Yes ☐ No

If "yes" what types?

_____

Part A. Section 2

1. Do you currently smoke tobacco or have you smoked in the last month? ☐ Yes ☐ No

2. Have you ever had any of the following conditions?

Seizures	☐ Yes ☐ No
Diabetes *(sugar disease)*	☐ Yes ☐ No
Allergic reactions that interfere with your breathing	☐ Yes ☐ No
Claustrophobia (fear of closed-in places)	☐ Yes ☐ No
Trouble smelling odors	☐ Yes ☐ No

3. Have you ever had any of the following pulmonary or lung problems?

Asbestosis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Chronic bronchitis	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No
Silicosis	☐ Yes ☐ No
Lung cancer	☐ Yes ☐ No
Pneumothorax (collapsed lung)	☐ Yes ☐ No
Broken ribs	☐ Yes ☐ No
Any chest injuries or surgeries	☐ Yes ☐ No
Any other known lung problem	☐ Yes ☐ No

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4. Do you currently have any of the following symptoms of pulmonary or lung illness?

Shortness of breath ☐ Yes ☐ No
Shortness of breath when walking fast on level ground or up a slight hill ☐ Yes ☐ No
Shortness of breath when walking with others at an ordinary pace on level ground ☐ Yes ☐ No
Have to stop for breath when walking at your own pace on level ground ☐ Yes ☐ No
Shortness of breath when washing or dressing yourself ☐ Yes ☐ No
Shortness of breath that interferes with your job ☐ Yes ☐ No
Coughing that produces phlegm (mucous or thick secretions) ☐ Yes ☐ No
Coughing that wakes you up early in the morning ☐ Yes ☐ No
Coughing that occurs mostly when you are lying down ☐ Yes ☐ No
Coughing up blood in the last month ☐ Yes ☐ No
Wheezing ☐ Yes ☐ No
Wheezing that interferes with your job ☐ Yes ☐ No
Chest pain when you breath deeply ☐ Yes ☐ No
Any other symptoms you think may be related to lung problems ☐ Yes ☐ No

5. Have you ever had any of the following cardiovascular or heart problems?

Heart attack ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Angina ☐ Yes ☐ No
Heart failure ☐ Yes ☐ No
Swelling in your legs or feet (not caused by walking) ☐ Yes ☐ No
Heart arrhythmia (irregular heart beats) ☐ Yes ☐ No
High blood pressure ☐ Yes ☐ No
Any other heart problem you have been told about ☐ Yes ☐ No

6. Have you ever had any of the following cardiovascular or heart symptoms?

Frequent pain or tightness in your chest ☐ Yes ☐ No
Pain or tightness in your chest during physical activity ☐ Yes ☐ No
Pain or tightness in your chest that interferes with your job ☐ Yes ☐ No
In the past two years, have you noticed your heart skipping or missing a beat ☐ Yes ☐ No
Heartburn or indigestion that is not related to eating ☐ Yes ☐ No
Other symptoms that may be related to heart or circulation problems ☐ Yes ☐ No

7. Do you currently take medication for any of the following problems

Breathing or lung problems ☐ Yes ☐ No
Heart trouble ☐ Yes ☐ No
Blood pressure ☐ Yes ☐ No
Seizures ☐ Yes ☐ No

8. If you have used a respirator, have you ever had any of the following problems?

Eye irritation ☐ Yes ☐ No
Skin allergies or rashes ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
General weakness or fatigue ☐ Yes ☐ No
Any other problems 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?

☐ Yes ☐ No

Employee Signature/Date:

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Note to employer: The following questions are required by OSHA's revised Respiratory Protection Standard (29 CFR 1910.134) for employees who will be using full-facepiece respirators or self-contained breathing apparatus units (SCBAs). These questions must be answered in addition to the questions contained in Section 1 and Section 2 of this questionnaire. If your employees show signs of musculoskeletal problems or other problems that would affect their use of a SCBA, be sure to have them get a follow-up medical exam.

Part A. Section 3

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?

Wear contact lenses	☐ Yes ☐ No
Wear glasses	☐ Yes ☐ No
Color blind	☐ Yes ☐ No
Any other eye or vision problem	☐ Yes ☐ No

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

13. Do you currently have any of the following problems?

Difficulty hearing	☐ Yes ☐ No
Wear a hearing aid	☐ Yes ☐ No
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?

Weakness in any of your arms, hands, legs or feet	☐ Yes ☐ No
Back pain	☐ Yes ☐ No
Difficulty fully moving your arms and legs	☐ Yes ☐ No
Pain or stiffness when you lean forward or backward at the waist	☐ Yes ☐ No
Difficulty fully moving your head up or down	☐ Yes ☐ No

15. Do you currently have any of the following musculoskeletal problems (continued)?

Difficulty fully moving your head from side to side	☐ Yes ☐ No
Difficulty bending at your knees	☐ Yes ☐ No
Difficulty squatting to the ground	☐ Yes ☐ No
Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.	☐ Yes ☐ No
Any other muscle or skeletal problem that interferes with using a respirator	☐ Yes ☐ No

Part B Any of the following questions may be added to the questionnaire at the discretion of the healthcare professional who will review the questionnaire.

1. Have you been in the military services?

☐ Yes ☐ No

If yes, were you exposed to biological or chemical agents? ☐ Yes ☐ No

2. How often are you expected to use the respirator(s)? Check <u>Yes</u> or <u>No</u> for all answers that apply to you.

Escape only	☐ Yes ☐ No
Emergency rescue only	☐ Yes ☐ No
Less that 5 hours per week	☐ Yes ☐ No
Less than 2 hours per day	☐ Yes ☐ No
2 to 4 hours per day	☐ Yes ☐ No
Over 4 hours per day	☐ Yes ☐ No

3. Will you be wearing protective clothing and/or equipment (other than the respirator) when using your respirator. ☐ Yes ☐ No

If yes, describe this protective clothing and/or equipment.

4. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases).

(Employee's signature)

(Date)