RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (MANDATORY)

**EMPLOYEE:** 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. Your employer must tell you how to send or deliver this questionnaire to the health care professional who will review it.

**Part A. Section 1. (Mandatory)** **Every employee selected to use any type of respirator must provide the following information (please print).**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date: | | | |  | | | | | | | |  | | | | |
| Name: | | | |  | | | | | | | |  | | | | |
| Job title: | | | | |  | | | | | | |  | | | | |
| Age: | |  | | | | Sex: M  F | | | Height: | |  | | | Weight: |  | |
| Phone number: | | | | | | | (     ) | | | |  | | | | | |
| A phone number where the health care professional  can reach you (include the Area Code): | | | | | | | | | | | | | (     ) | | |  |
| The best time to phone you at this number: | | | | | | | | | |  | | | | | |  |
| Has your employer told you how to contact the health care professional  who will review this questionnaire (check one)? Yes  No | | | | | | | | | | | | | | | | |
| 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 type, powered-air purifying, supplied-air, self-contained breathing apparatus). | | | | | | | | | | | | | |
| Have you worn a respirator (check one)? Yes  No | | | | | | | | | | | | | | | | |
| If “yes,” what type(s)? | | | | | | | |  | | | | | | | | |

**Part A. Section 2. (Mandatory) Every employee selected to use any type of respirator must answer questions 1 through 9 below (please check “yes” or “no”).**

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

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. Silicosis Yes  No

c. Asthma Yes  No

d. Pneumothorax (collapsed lung) Yes  No

e. Chronic bronchitis Yes  No

f. Lung cancer Yes  No

g. Emphysema Yes  No

h. Broken ribs Yes  No

i. Pneumonia Yes  No

j. Any chest injuries or surgeries Yes  No

k. Tuberculosis Yes  No

l. Any other lung problem that you have 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 breath 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

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 problems that you have 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 2 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 have used a respirator, have you *ever* had any of the following   
problems? (If you have *never* used a respirator continue to question 9)

a. Eye irritation Yes  No

b. Skin allergies or rashes Yes  No

c. Anxiety Yes  No

d. General weakness of fatigue Yes  No

e. Any other problem that interferes with your use of a respirator Yes  No

9. Would you like to discuss your answers with the health care professional   
who will review this questionnaire? Yes  No

**Questions 10 to 15 must be answered if you will use either a full-face respirator or a self-contained breathing apparatus (SCBA).**

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 ear drum? 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

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 pounds Yes  No

j. Any other muscle or skeletal problem that interferes with using

a respirator Yes  No

**Part B. Section 1. The health care professional who will review this questionnaire may add these questions and any other questions not listed at their discretion.**

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 are working   
under these condition? 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. Coal (for example, mining) Yes  No

c. Silica (e.g., sandblasting) Yes  No

d. Iron Yes  No

e. Tungsten/cobalt (grinding or welding this material) Yes  No

f. Tin Yes  No

g. Dusty environments Yes  No

h. Beryllium Yes  No

i. Any other hazardous exposures Yes  No

j. Aluminum Yes  No

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| If “yes,” describe these exposures: |
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| --- | --- |
| 4. | List any second jobs or side businesses you have: |
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| --- | --- |
| 5. | List your previous occupations: |
|  |  |

|  |  |
| --- | --- |
| 6. | List your current and previous hobbies: |
|  |  |

7. Were you ever 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

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| If “yes,” name the medications if you know them: |
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**Part B. Section 2. Supplemental information for the health care professional filled out by the employer.**

10. Will the employee use any of the following items with your respirator(s)?

a. HEPA filters Yes  No

b. Canisters (i.e., gas masks) Yes  No

c. Cartridges Yes  No

11. How often will the employee use the respirator(s)? (Mark “yes” or “no”   
for all answers that apply.)

a. Escape only (no rescue) Yes  No

b. Less than 2 hrs. per day Yes  No

c. Emergency rescue only Yes  No

d. 2 to 4 hrs. per day Yes  No

e. Less than 5 hrs. per week Yes  No

f. over 4 hrs. per day Yes  No

12. When the employee uses the respirator(s), is their 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 light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while 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, drilling, nailing performing assembly work, or transferring a moderate load (about 35 pounds) 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 pounds) on a level surface.*

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

If “yes,” how long does this period last during the average shift?

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| --- | --- | --- | --- |
| hrs. |  | mins. |  |

*Examples of heavy work are lifting a heavy load (about 50 pounds) 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 pounds).*

13. Will the employee wear protective clothing and/or equipment (other than   
the respirator) when using their respirator? Yes  No

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| If “yes,” describe this protective clothing and/or equipment: |
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14. Will they be working in hot conditions (temperature more than 77 degrees F)? Yes  No

15. Will they be working in humid conditions? Yes  No

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| --- | --- |
| 16. | Describe the work they will be doing while using their respirator(s): |
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| --- | --- |
| 17. | Describe any special or hazardous conditions they might encounter when using a respirator(s) (for example, confined spaces, life threatening gases): |
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18. Provide the following information, if you know it, for each toxic substance that they will be exposed to when using their 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: |  | | | |
| Name of any other toxic substances that they will be exposed to while using a respirator: | | | | |
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| --- | --- |
| 19. | Describe any special responsibilities they will have while using their respirator(s) that may affect the safety and well-being of others (i.e., rescue, security): |
|  |  |