McLeod
Occupational Health

555 East Cheves street
Florence, SC 29506-2617
(843) 777-5146

OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

Part A. Section 1. (Mandatory) Every employee who has been selected to use any type of respirator must provide the following information. (Please Print)

1. Today's date: _____ 2. Your name: _____ 3. Your age to nearest year: _____
4. Sex (circle one): Male/Female 5. Height:_____ft____in. 6. Weight:_____ 7. Job Title:_____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include area code): (____) _____
9. The best time to phone you at this number:_____
10. Has your employer told you how to contact the health care professional who will review this questionnaire? (Circle one) Yes/No
11. Check the type of respirator you will use (you can check more than one category)
    A _____ N (not resistant to oil), R (resistant to oil), or P (oil Proof) disposable respirator (filter mask, non-cartridge type only).
    B _____ Other type (for example, half or full-face piece type, powered-air purifying, Supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator (circle one) Yes/No If "yes" what type(s):_____
13. Have you been assigned to wear a respirator within the last 12 months? (Circle one) Yes/No

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 circle "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. 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
   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 hear problems 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 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 to your heart……...……...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.)
   A. Eye irritation……Yes/No
   B. Skin allergies or rashes……Yes/No
   C. Anxiety (due to wearing a respirator)……..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?……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
    D. Any other eye or vision problems……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 problems……..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. Difficulty climbing a flight of stairs or a ladder carrying more more than 25 lbs…..…… Yes/No
    J. Any other muscle or skeletal problems that interferes with using a respirator……...Yes/No

Comments on Positive Responses:

_____

_____

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Employee's Signature:_____ Date:_____

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PLHCP REVIEW: BP _____ Pulse _____

Further Studies Indicated? Yes_____ No _____

Comments:_____

_____

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Signature:_____ (NP, RN, PA, MD/Do)