

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).

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 or 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 blindYes No
 - d. Any other eye or vision problemYes 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 aidYes 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 painYes 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 sideYes 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 respiratorYes 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

If "yes," describe these exposures:

4. List any second jobs or side businesses you have:

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

If "yes," name the medications if you know them:

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?

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

If "yes," describe this protective clothing and/or equipment:

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

16. Describe the work they will be doing while using their respirator(s):

17. Describe any special or hazardous conditions they might encounter when using a respirator(s) (for example, confined spaces, life threatening gases):

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:

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):
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