OSHA Respirator Medical Evaluation Questionnaire

To the employee: Can you read? (check one) Yes☐ No☐ ?☐

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, and 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. The following information must be provided by every employee who has been selected to use **any type of respirator** (please print).

1. Today's date: _____ Your medical record number: _____
2. If you do not have a medical record number please provide SS# _____-____-_____
3. Your employer: _____ Your job: _____
4. Your name: _____Maiden Name: _____
5. Your age (to nearest year):_____ DOB _____
6. Sex : (check one) ☐ MALE ☐ FEMALE
7. Your height: _____ft, _____in
8. Your weight: _____lbs.
9. Your job title: _____
10. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):_____
11. The best time to phone you at this number: _____
12. Has your employer told you how to contact the health care professional who will review this questionnaire (check one)? Yes☐ No☐ ?☐
13. 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-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
14. Have you worn a respirator (check one)? Yes☐ No☐ ?☐ If YES, what type(s):

_____

Part A. Section 2. Questions 1 through 14 below must be answered by every employee who has been selected to use any type of respirator. (Please check YES or NO. If unsure check ?).

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☐ ?☐
   - f. High cholesterol? 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☐ ?☐
     - i) How long ago did you have pneumonia? _____
     - ii) Has the pneumonia completely resolved? 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☐ ?☐
     - i) How many ribs did you break? _____
     - ii) Do you currently have any rib pain? Yes☐ No☐ ?☐
     - iii) Did your rib fracture result in any shortness of breath? Yes☐ No☐ ?☐
   - k. Any chest injuries or surgeries? Yes☐ No☐ ?☐
   - l. Any other lung problem that you've been told about? Yes☐ No☐ ?☐
     - i) Describe _____

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 heart problem 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 two 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'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 question 9)

a.	Eye irritation?	Yes□	No□	?□
b.	Skin allergies or rashes?	Yes□	No□	?□
c.	Anxiety or Claustrophobia?	Yes□	No□	?□
d.	General weakness or fatigue?	Yes□	No□	?□
e.	Any other problem that interferes with your use of a respirator.	Yes□	No□	?□

9. How often are you expected to use the respirator(s)
(check YES or NO for all answers that apply to you)?

a.	Escape only (no rescue):	Yes□	No□	?□
b.	Emergency rescue only:	Yes□	No□	?□
c.	Less than 5 hours per week:	Yes□	No□	?□
d.	Less than 2 hours per day:	Yes□	No□	?□
e.	2 to 4 hours per day:	Yes□	No□	?□
f.	Over 4 hours per day:	Yes□	No□	?□

10. Work requiring respirator use is (check all that apply):

LIGHT MODERATE HEAVY

Examples of **light** work are: sitting while writing, performing light assembly work, and controlling machines.
Examples of **moderate** work are: standing while nailing, transferring a moderate load (about 35 lbs.) at trunk level, and walking on a level surface about 2 mph.
Examples of **heavy** work are: lifting a heavy load (about 50 lbs) from the floor to your waist, shoveling, and standing while bricklaying.

11. Do you normally have a beard, goatee, mustache, or other facial hair growth? Yes□ No□ ?□
   a) Does your facial hair come in contact the seal of the respirator? Yes□ No□ ?□

12. How much exercise (outside of work) do you get in a typical week?
Please explain

13. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? Yes□ No□ ?□

Questions 14 to 19 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.

14. Have you ever lost vision in either eye

(temporarily or permanently)? Yes☐ No☐ ?☐

15. 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☐ ?☐

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

17. 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☐ ?☐

18. Have you ever had a back injury? Yes☐ No☐ ?☐
    a. Has your back injury completely resolved? Yes☐ No☐ ?☐
        i) As of what date did the back injury resolve? _____
    b. Do you have any current restrictions regards lifting, carrying, bending, or twisting? Yes☐ No☐ ?☐

19. 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 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 than 25 lbs? Yes☐ No☐ ?☐
    j. Any other muscle or skeletal problem that interferes with using a respirator? Yes☐ No☐ ?☐

Signature: _____ Date: _____

Reviewed by: _____ Date: _____

KAISER PERMANENTE®

Name: _____

MR #: _____

MEDICAL INFORMATION ABOUT YOU

IMPRINT AREA

NOTICE

MEDICAL INFORMATION ABOUT YOU WILL BE DISCLOSED TO YOUR EMPLOYER.

Information about your health is personal. We are committed to protecting that information. When we treat you or evaluate your health at Kaiser Permanente Occupational Health Centers, we create a record of the services. We need this record to provide you with quality care and to comply with certain legal requirements.

However, your employer requested that we provide you with the services you are receiving today for the purposes of workplace medical surveillance or the evaluation of work-related illness and injuries. You employer needs this information to comply with OSHA, the Mine Safety and Health Administration (MSHA), or the requirements of State laws having a similar purpose. Federal and State law permit us to disclose the results of our examination to your employer. The medical information disclosed will be limited to the clinician's findings regarding the medical surveillance or the work-related illness or injury. Some examples of employer requested services that we perform include:

- Under Federal Title 29 (CFR) parts 1904 through 1928, 30 CFR parts 50 through 90, and California Title 8 and other statutes, employers must provide various regulated/surveillance evaluations which include the following:
  - Respirator Evaluations
  - Asbestos Evaluations
  - Hazardous Waste Work Evaluations
  - Hearing Conservation Evaluations
  - Beryllium Evaluations
  - Pesticide Evaluations
  - Lead Evaluations
  - Diver Evaluations
  - Department of Energy Evaluations
  - Mine Safety Evaluations
- Evaluation and treatment of workers' compensation injuries and illnesses

I received a copy of this notice: _____ Date: _____

EXAMINEE'S SIGNATURE