Occupational Health Office Use Only:	*Reviewed by _____Date _____*	*Requires a respirator physical:*	***Yes***	***No***

CARILION CLINIC OCCUPATIONAL HEALTH

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (Mandatory)

To the **EMPLOYER**:	Answers to questions in Section 1, and to question 9 in section 2 of Part A do not require a medical examination.		
To the **EMPLOYEE**:	Can you read?	❑ **Yes**	❑ **No**
Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place 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. (MANDATORY) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

Today's Date:	**Your Name:**	**Age:**	**Date of Birth:**
Company:	**Your job title:**		
▫**Male** ▫**Female**	**Height:**	**Weight:**	
Address:			
Phone number where you can be reached by the health care professional who reviews the questionnaire:	( )		
The best time to reach you at this number:			
Has your employer told you how to contact the health care professional who will review this questionnaire?	❑ **Yes**	❑ **No**	

Check the type of respirator you will use: (You can check more than one category)

a. _____ N, R, or P disposable respirator (N95, filter-mask, non-cartridge type only)	c. _____ Full-face respirator
b. _____ Half-face respirator	d. _____ Powered-air purifying (PAPR)
	e. _____ Self-Contained Breathing Apparatus (SCBA)

Have you ever worn a respirator? If "yes," what type(s)?	❑ **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.

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?		
Seizures (fits)	❑ **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**
Pneumothorax (collapsed lung)	❑ **Yes**	❑ **No**
Lung cancer	❑ **Yes**	❑ **No**
Broken ribs	❑ **Yes**	❑ **No**
Any chest injuries or surgeries	❑ **Yes**	❑ **No**
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?		
Shortness of breath	❑ **Yes**	❑ **No**
Shortness of breath when walking fast on level ground or walking up a slight hill or incline	❑ **Yes**	❑ **No**
Shortness of breath when walking with other people 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 (thick sputum/mucous)	❑ **Yes**	❑ **No**
Coughing that wakes you 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 breathe deeply	❑ **Yes**	❑ **No**
Other symptoms you think may be related to lung problems	❑ **Yes**	❑ **No**
5) Have you *EVER* had any of the following Cardiovascular or heart problem?		
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 (heart beating irregularly)	❑ **Yes**	❑ **No**
High blood pressure	❑ **Yes**	❑ **No**
Any other heart problem that you've been told about	❑ **Yes**	❑ **No**
6) Have you *EVER* had in 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**
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?		
Breathing or lung problems	❑ **Yes**	❑ **No**
Heart trouble	❑ **Yes**	❑ **No**
Blood pressure	❑ **Yes**	❑ **No**
Seizures (fits)	❑ **Yes**	❑ **No**
8) If you have 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.)		
Eye irritation	❑ **Yes**	❑ **No**
Skin allergies or rashes	❑ **Yes**	❑ **No**
Anxiety	❑ **Yes**	❑ **No**
General weakness or fatigue	❑ **Yes**	❑ **No**
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 to this questionnaire?	❑ **Yes**	❑ **No**

Questions below must be answered by every employee who has been selected to use either a full-face piece 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?		
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 ear drum	❑ **Yes**	❑ **No**
13) Do you CURRENTLY have any of the following hearing 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**
Difficulty fully moving your head side to side	❑ **Yes**	❑ **No**
Difficulty bending at your knees	❑ **Yes**	❑ **No**
Difficulty squatting to the ground	❑ **Yes**	❑ **No**
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, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

Have you ever worked with any of the materials, or under any conditions below?		
Asbestos	❑ **Yes**	❑ **No**
Silica (as in sandblasting)	❑ **Yes**	❑ **No**
Tungsten/Cobalt (e.g., grinding or welding this material)	❑ **Yes**	❑ **No**
Beryllium	❑ **Yes**	❑ **No**
Aluminum	❑ **Yes**	❑ **No**
Coal (for example, mining)	❑ **Yes**	❑ **No**
Iron	❑ **Yes**	❑ **No**
Tin	❑ **Yes**	❑ **no**
Dusty environments	❑ **Yes**	❑ **No**
Any other hazardous exposures	❑ **Yes**	❑ **No**
If "yes," describe these exposures:		
List your previous occupations:		
List your current and previous hobbies:		
Have you been in the military services	❑ **Yes**	❑ **No**
If "yes," were you exposed to biological or chemical agents (either in training/combat)	❑ **Yes**	❑ **No**
Have you worked on a HAZMAT team	❑ **Yes**	❑ **No**

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:		
Will you be using any of the following items with your respirator(s)?	❑ **Yes**	❑ **No**
HEPA Filters	❑ **Yes**	❑ **No**
Canisters (for example, gas masks)	❑ **Yes**	❑ **No**
How often are you expected to use the respirator(s)? *(check Yes/No for <u>all answers that apply</u>.)*		
Escape only (no rescue)	❑ **Yes**	❑ **No**
Emergency rescue only	❑ **Yes**	❑ **No**
Less than 5 hours per week	❑ **Yes**	❑ **No**
2 to 4 hours per day	❑ **Yes**	❑ **No**
Over 4 hours per day	❑ **Yes**	❑ **No**
During the work period you are using the respirator(s), is your work effort: a. *<u>Light</u>* (less than 200kcal per hour) Examples of light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3lbs) or controlling machines.	❑ **Yes**	❑ **No**
If "yes," how long does this period last during the average shift: ____hrs.____mins.		
b. *<u>Moderate</u>* (200-350 kcal per hour) Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35lbs) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade and 3 mph; or pushing a wheelbarrow with a heavy load (about 100lbs) on a level surface.	❑ **Yes**	❑ **No**
If "yes," how long does this period last during the average shift: ____hrs.____mins.		
c. *<u>Heavy</u>* (above 35 kcal per hour) Examples of heavy work are lifting a heavy load (about 50 lbs) 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 lbs).	❑ **Yes**	❑ **No**
If "yes," how long does this period last during the average shift: ____hrs.____mins.		
Will you be wearing protective clothing and/or equipment	❑ **Yes**	❑ **No**
If "yes," describe this protective clothing and/or equipment		
Will you be working under humid conditions	❑ **Yes**	❑ **No**
Will you be working under hot conditions: (temperature exceeding 77 degrees F)	❑ **Yes**	❑ **No**
Describe the work you'll be doing while you're using your respirator(s):		
Describe any special or hazardous conditions you might be in when you're using your respirator(s) (for example, confined spaces, life-threatening gases):		
Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):		
a. **<u>Name of the first toxic substance</u>**: _____ Estimated maximum exposure level per shift: _____ Duration of exposure per shift: _____ b. **<u>Name of the second toxic substance</u>**: _____ Estimated maximum exposure level per shift: _____ Duration of exposure per shift: _____ c. **<u>Name of the third toxic substance</u>**: _____ Estimated maximum exposure level per shift: _____ Duration of exposure per shift: _____		
List the name of any other toxic substances that you'll be exposed to while using your respirator:		
Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others: (for example: rescue, security)		