OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE FORM

SECTION I – To be completed by the employee. Please print legibly.

Today' date	Employee Name:	Job title	Sex:

Date of Birth	Age (to nearest year)	Height feet inches	Weight lbs.	Employee ID Number	Last 4 #SS

Phone number where you can be reached by the health-care professional who reviews this questionnaire (include area code) ( )	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? Yes ☐ No ☐

Type of respirator your will use (check all that apply)

☐ N 95-disposable respirator

☐ PAPR – loose-fitting

☐ Other type_____

Have you worn a respirator? Yes ☐ No ☐

If "yes," what types?

Yes ☐ No ☐ Have you ever been fit tested previously for a respirator?

Yes ☐ No ☐ if so, have you ever failed or been unable to complete the test?

Questionnaire for N-95 or PAPR Users

Yes ☐	No ☐	Are you able to read this form?	Yes ☐	No ☐	f. Shortness of breath that interferes with your job
Yes ☐	No ☐	**1. Do you currently or have you smoked tobacco during the previous month? If "yes"**	Yes ☐	No ☐	g. Coughing that produces phlegm (thick sputum)
		a. At what age did you start smoking?	Yes ☐	No ☐	h. Coughing that wakes you early in the morning
		b. How long ago did you quit smoking?	Yes ☐	No ☐	i. Coughing that occurs primarily when you are lying down
		c. How many packs per day did or do you smoke?	Yes ☐	No ☐	j. Coughing up blood in the last month
		2. Have you ever had any of the following conditions?	Yes ☐	No ☐	k. Wheezing
Yes ☐	No ☐	a. Seizures (fi ts)	Yes ☐	No ☐	l. Wheezing that interferes with your job
Yes ☐	No ☐	b. Diabetes (sugar disease)	Yes ☐	No ☐	m. Chest pain when you breath deeply
Yes ☐	No ☐	c. Allergic reactions that interfere with your breathing	Yes ☐	No ☐	n. Any other symptoms that you think might be related to lung problems
Yes ☐	No ☐	d. Claustrophobia (fear of closed-in places)			**5. Have you ever had any of the following cardiovascular or heart symptoms?**
Yes ☐	No ☐	e. Trouble smelling odors	Yes ☐	No ☐	a. Heart attack
		3. Have you ever had any of the following pulmonary or lung problems?	Yes ☐	No ☐	b. Stroke
Yes ☐	No ☐	a. Asbestosis	Yes ☐	No ☐	c. Angina
Yes ☐	No ☐	b. Asthma	Yes ☐	No ☐	d. Heart failure
Yes ☐	No ☐	c. Chronic Bronchitis	Yes ☐	No ☐	e. Swelling in your legs or feet (not caused by walking)
Yes ☐	No ☐	d. Emphysema	Yes ☐	No ☐	f. Heart arrhythmia (heart beating irregularly)
Yes ☐	No ☐	e. Pneumonia	Yes ☐	No ☐	g. High blood pressure
Yes ☐	No ☐	f. Tuberculosis	Yes ☐	No ☐	h. Any other heart problem that you have been told about
Yes ☐	No ☐	g. Silicosis			**6. Have you ever had any of the following cardiovascular or heart problems?**
Yes ☐	No ☐	h. Pneumothorax (collapsed lung)	Yes ☐	No ☐	a. Frequent pain or tightness in your chest
Yes ☐	No ☐	i. Lung cancer	Yes ☐	No ☐	b. Pain or tightness in your chest during physical activity
Yes ☐	No ☐	j. Broken ribs	Yes ☐	No ☐	c. Pain or tightness in your chest that interferes with your job
Yes ☐	No ☐	k. Any chest injuries or surgeries	Yes ☐	No ☐	d. In the previous 2 years, have you noticed your heart skipping or missing a beat?
Yes ☐	No ☐	l. Any other lung problem that you have been told about	Yes ☐	No ☐	e. Heartburn or indigestion that is not related to eating
		4. Do you currently have any of the following symptoms of pulmonary or lung illness?	Yes ☐	No ☐	f. Any other symptoms that you think might be related to heart or circulation problems
Yes ☐	No ☐	a. Shortness of breath			**7. Do you currently take medications for any of the following problems?**
Yes ☐	No ☐	b. Shortness of breath when walking quickly on level ground or walking up a slight hill or incline	Yes ☐	No ☐	a. Breathing or lung problems
Yes ☐	No ☐	c. Shortness of breath when walking with other people at an ordinary pace on level ground	Yes ☐	No ☐	b. Heart trouble
Yes ☐	No ☐	d. Have to stop for breath when walking at your own pace on level ground	Yes ☐	No ☐	c. Blood pressure
Yes ☐	No ☐	e. Shortness of breath when washing or dressing yourself	Yes ☐	No ☐	d. Seizures (fits)

Name: DOB:

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (cont.)

If yes, please list the medications:		Yes ☐ No ☐	a. Skin allergies or rashes
		Yes ☐ No ☐	c. Anxiety
		Yes ☐ No ☐	d. General weakness or fatigue
	8. If you have used a respirator, have you ever had any of the following problems? (if you have never used a respirator, check here ____and go to question 9.)	Yes ☐ No ☐	e. Any other problem that interferes with your use of a respirator
Yes ☐ No ☐	a. Eye irritation	Yes ☐ No ☐	**9. Would you like to talk with the health-care professional who will review this questionnaire about your answers to this questionnaire?**

Employee Signature **Date**

SECTION II – To be completed by the employee and submitted to Occupational Health Nurse (OHN)

Type of work performed: Level of work effort while wearing respirator:

☐ Light (less than 200 Kcal per hour)
Examples of light work effort are sitting while working, typing, drafting, or performing light assembly work, or standing while operating a drill press (1-3 lbs.) or controlling machines.
If "yes" how long does this period last during the average shift _____Hours _____Minutes

☐ Moderate (200 to 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 35 lbs.) at truck level; walking of a level surface about 2 mph or down a 5-degree about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.
If "yes" how long does this period last during the average shift _____Hours _____Minutes

☐ Heavy (above 350 Kcal per hour)
Examples of heavy work are lifting a heavy load (about 50 lbs.) from the fl oor 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.)
If "yes" how long does this period last during the average shift _____Hours _____Minutes

Will you be wearing protective clothing and/or equipment (other than your respirator) when you are using your respirator? Yes ☐ No ☐
If yes, describe this protective clothing and/or equipment: _____

Extent of respirator use: Daily ☐ At least weekly ☐ Less than once a week ☐ Rarely or emergency only ☐

Estimated length of respirator use per session: average _____hours maximum _____hours emergency _____hours

Do you have any facial hair or facial deformities that would interfere with a good face seal? Yes ☐ No ☐

Employee Signature **Date**

SECTION III – To be completed by the Occupational Health Nurse (OHN)

☐ Approved for FIT test ☐ Referred for Medical Evaluation

OHN Print Name **OHN Signature** **Date**

SECTION IV – To be completed by the Physician or Mid Level Provider when referred by an Occupational Health Nurse.

Medical evaluation for respirator use under work conditions described above:
Medically released ☐ No restrictions ☐ Specifi c restrictions (see below) ☐ No use permitted ☐

Comments/Restrictions:

Licensed Healthcare Provider Print Name **Licensed Healthcare Provider Signature** **Date**