OSHA Respirator Medical Evaluation Questionnaire

Can you read (check one): Yes ☐ No ☐

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

Name: _____ Date: _____

Job Title: _____

Department: _____

Supervisor: _____

Social Security Number (for Health Services records only): _____

Date of Birth:: _____

Sex (check one): Male ☐ Female ☐

Height: _____ ft. _____ in. Weight: _____ lbs.

A phone number where you can be reached by the health care professional who reviews this questionnaire (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):

☐ N, R, or P disposable respirator (filter-mask, non- cartridge type only).
☐ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Do you have any of the following conditions which could affect respirator fit?

☐ Clean Shaven
☐ 1-2 Day Growth
☐ 2+ Day Growth
☐ Mustache
☐ Facial Scar
☐ Dentures Absent
☐ Glasses
☐ None

Comments:_____

Have you worn a respirator before? (check one):

Yes ☐ No ☐

If "Yes," what type(s): _____

The questions below must be answered by every individual who has been selected to use any type of respirator (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?

Yes ☐	No ☐	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

3. Have you **ever had** any of the following pulmonary or lung problems?

Yes ☐	No ☐	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

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

Yes ☐	No ☐	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)
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 ☐	Any other symptoms that you think may be related to lung problems

5. Have you **ever had** any of the following cardiovascular or heart problems?

Yes ☐	No ☐	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

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

Yes ☐	No ☐	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

7. Do you **currently** take medication for any of the following problems?

Yes ☐	No ☐	Breathing or lung problems
Yes ☐	No ☐	Heart trouble
Yes ☐	No ☐	Blood pressure
Yes ☐	No ☐	Seizures

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) :

Yes ☐	No ☐	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

☐ Check here if you have never used a respirator.

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 10 to 15 below must be answered by every individual who has been selected to use either a **full-face piece respirator or a self-contained breathing apparatus (SCBA)**. For individuals 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?

Yes ☐	No ☐	Wear contact lenses
Yes ☐	No ☐	Wear glasses
Yes ☐	No ☐	Color blind
Yes ☐	No ☐	Any other eye or vision problem

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?

Yes ☐	No ☐	Difficulty hearing
Yes ☐	No ☐	Wear a hearing aid
Yes ☐	No ☐	Any other hearing or ear problem

14. Have you **ever had** a back injury?

Yes ☐ No ☐

15. Do you **currently** have any of the following musculoskeletal problems?

Yes ☐	No ☐	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 leaning forward/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 25 lbs +
Yes ☐	No ☐	Any other muscle or skeletal problem that interferes with using a respirator