Occupational Health Services

Email medical questionnaire to rkaeserohs@comcast.net or

Fax to (904) 998-9906 Phone (904) 998-9913

Company: _____ Location: _____ Job #: _____

OSHA Respirator Medical Evaluation Questionnaire

To be completed by employer:

1. Type and weight of the respirator to be used: _____
2. Duration and frequency of respirator use (including use for rescue and escape): _____
3. Expected physical work effort: ☐ Heavy ☐ Moderate ☐ Light
4. Additional protective clothing and equipment required: _____
5. Temperature and humidity extremes: _____

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 piece type, powered air purifying, supplied air, self-contained breathing apparatus)

To be completed by 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 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.

Today's Date:	Print Your Name:		Your Sex: ☐M ☐F
Your Height: ft. in.	Your weight:	Your Job title:	Last four SS#:
Phone number:	The best time to reach you at this number is:		

Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No

Have you ever worn a respirator? ☐ Yes ☐ No Types: Your AGE:

1. Do you currently smoke tobacco or have you smoked tobacco in the past month? ☐ Yes ☐ No

2. Have you ever had any of the following conditions?
   a. ☐Yes ☐No Seizures
   b. ☐Yes ☐No Diabetes
   c. ☐Yes ☐No Allergic reactions that interfere with breathing
   d. ☐Yes ☐No Claustrophobia
   e. ☐Yes ☐No Trouble smelling odors

3. Have you ever had any of the following lung conditions?
   a. ☐Yes ☐No Asbestosis
   b. ☐Yes ☐No Asthma
   c. ☐Yes ☐No Tuberculosis
   d. ☐Yes ☐No Emphysema
   e. ☐Yes ☐No Pneumonia
   f. ☐Yes ☐No Chronic bronchitis
   h. ☐Yes ☐No Pneumothorax
   i. ☐Yes ☐No Broken ribs
   j. ☐Yes ☐No Chest injury
   k. ☐Yes ☐No Chest surgery
   l. ☐Yes ☐No Silicosis

4. Do you currently have any of the following symptoms?
   a. ☐Yes ☐No Shortness of breath
   b. ☐Yes ☐No Shortness of breath when walking fast on ground level or up a slight incline
   c. ☐Yes ☐No Shortness of breath when walking with other people at an ordinary pace on level ground
   d. ☐Yes ☐No Have to stop for breath when walking at your own pace on level ground
   e. ☐Yes ☐No Shortness of breath when washing or dressing
   f. ☐Yes ☐No Shortness of breath that interferes with your job
   g. ☐Yes ☐No Coughing that produces phlegm
   h. ☐Yes ☐No Coughing that wakes you in the morning
   i. ☐Yes ☐No Coughing when you are lying down
   j. ☐Yes ☐No Coughing up blood in the past month
   k. ☐Yes ☐No Wheezing that interferes with your job
   L. ☐Yes ☐No Chest pain when you breathe deeply
   m. ☐Yes ☐No Any other symptoms that you thing that may be related to lung problems

Explain positive responses:

5. Have you ever had any of the following cardiovascular or heart problems?
   a. ☐Yes ☐No Heart Attack
   b. ☐Yes ☐No Stroke
   c. ☐Yes ☐No Angina
   d. ☐Yes ☐No Heart Failure
   e. ☐Yes ☐No Swelling in hands or feet
   f. ☐Yes ☐No Heart arrhythmia
   g. ☐Yes ☐No Hypertension
   h. ☐Yes ☐No Other heart problem

6. Have you ever had any of the following heart symptoms?
   a. ☐Yes ☐No Frequent chest pain I tightness
   b. ☐Yes ☐No Chest pain or tightness during exercise
   c. ☐Yes ☐No Chest pain or tightness that interferes with work
   d. ☐Yes ☐No Heart "skipping" or missed beats during past 2 years
   e. ☐Yes ☐No Heartburn or indigestion not related to eating
   f. ☐Yes ☐No Any other symptoms you think may be heart related

7. Do you currently take medication for any of the following?
   a. ☐Yes ☐No Breathing or lung problem
   b. ☐Yes ☐No Heart trouble
   c. ☐Yes ☐No Blood pressure
   d. ☐Yes ☐No Seizures

8. If you've used a respirator, have you ever had any of the following?
   a. ☐Yes ☐No Eye irritation
   b. ☐Yes ☐No Skin allergies
   c. ☐Yes ☐No Other problems that interfere with respirator use
   d. ☐Yes ☐No Anxiety
   e. ☐Yes ☐No General weakness

9. ☐Yes ☐No Would you like to talk to the health care professional about your answers to this questionnaire?

10. ☐ Yes ☐ No Have you ever lost vision in either eye (temporarily or permanently?

11. Do you currently have any of the following vision problems?
    a. ☐Yes ☐No Wear contact lenses
    b. ☐Yes ☐No Wear glasses
    c. ☐Yes ☐No Color blind
    d. ☐Yes ☐No Any other eye or vision problem

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

13. Do you currently have any of the following hearing problems?
    a. ☐Yes ☐No Difficulty hearing
    b. ☐Yes ☐No Wear a hearing aid
    c. ☐Yes ☐No Any other hearing or ear problem

14. ☐Yes ☐No Have you ever had a back injury?

15. Do you currently have any of the following musculoskeletal problems?
    a. ☐Yes ☐No Weakness in any of your arms, hands, legs or feet
    b. ☐Yes ☐ No Back pain

Signature Date