



**OSHA Respirator
Medical Evaluation
Questionnaire**

4402 Shipyard Blvd., Wilmington, NC 28403 (910) 452-7000

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 (check one): Yes No

Your employer must allow you to answer the 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. (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: _____

Your age (to nearest year): _____ D.O.B. _____ Sex (check one): Male Female

Your height: _____ ft. _____ in. Your weight: _____ lbs.

Your job title: _____

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

Have you worn a respirator (check one): Yes No

If "yes", what type(s)? _____

Part A. Section 2 (Mandatory) Questions 1 through 9 must be answered by every employee who has been selected to use any type of respirator (please check "yes" or "no")

1. Do you currently smoke tobacco, or have smoked tobacco in the last month? Yes No
2. Have you ever had any of the following conditions?
Seizures 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 problems 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

Part A. Section 2 (Mandatory) Continued (please check "yes" or "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 laying down: Yes No
Coughing up blood in the last month: Yes No Wheezing: Yes No
Wheezing that interfere 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: Yes No
5. Have you ever had any of the following cardiovascular or heart problems?
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 any 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 problems 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: 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 to question #9)
Eye irritation: Yes No Skin allergies or rashes: Yes No
Anxiety: Yes No General weakness or fatigue: Yes No
Any other problems that interfere 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 10 through 15 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 are 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 bending 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 problems that interfere with using a respirator: Yes No