

Respiratory Protection Medical Evaluation Questionnaire

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:

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.

Are you able to read and understand the questions contained in this evaluation? Yes No

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

Name: _____ Today's Date: ____ / ____ / ____

Date of Birth: ____ / ____ / ____ Height: _____ ft. _____ in. Weight: _____ lbs. Sex: Male Female

Phone: (_____) _____ - _____ The best time to reach you at this number: _____

Job title: _____

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 may check more than one):

- | | |
|---|--|
| <input type="checkbox"/> Filtering Facepiece (N95, e.g., for hospitals/clinics) | <input type="checkbox"/> Powered air purifying respirator (PAPR) |
| <input type="checkbox"/> Half face air purifying respirator (APR) | <input type="checkbox"/> Self contained breathing apparatus (SCBA) |
| <input type="checkbox"/> Full face APR | <input type="checkbox"/> Air line |

Have you ever worn a respirator? Yes No If "yes," what type(s)? _____

Part A.

Questions 1 through 9 must be answered by every employee who has been selected to use any type of respirator.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Do you <i>currently</i> smoke tobacco, or have you smoked tobacco in the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you <i>ever had</i> any of the following conditions? | | |
| a. Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Diabetes (sugar disease) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Allergic reactions that interfere with your breathing | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Claustrophobia (fear of closed in places) | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Trouble smelling odors | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you <i>ever had</i> any of the following pulmonary or lung problems? | | |
| a. Asbestosis | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Chronic bronchitis | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Emphysema | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Silicosis | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Pneumothorax (collapsed lung) | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Lung cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Broken ribs | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Any chest injuries or surgeries | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Any other lung problem that you have been told about | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|--|--------------------------|--------------------------|
| 4. Do you <i>currently</i> have any of the following symptoms of pulmonary or lung illness? | | |
| a. Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Shortness of breath when walking with other people at an ordinary pace on level ground | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have to stop for breath when walking at your own pace on level ground | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Shortness of breath when washing or dressing yourself | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Shortness of breath that interferes with your job | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Coughing that produces phlegm (thick sputum) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Coughing that wakes you early in the morning | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Coughing that occurs mostly when you are lying down | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Coughing up blood in the last month | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Wheezing | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Wheezing that interferes with your job | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Chest pain when you breathe deeply | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Any other symptoms that you think may be related to lung problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you <i>ever had</i> any of the following cardiovascular or heart problems? | | |
| a. Heart attack | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Angina | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Heart failure | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Swelling in your legs or feet (not caused by walking) | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Heart arrhythmia (heart beating irregularly) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Any other heart problem that you have been told about | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you <i>ever had</i> any of the following cardiovascular or heart symptoms? | | |
| a. Frequent pain or tightness in your chest | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Pain or tightness in your chest during physical activity | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Pain or tightness in your chest that interferes with your job | <input type="checkbox"/> | <input type="checkbox"/> |
| d. In the past two years, have you noticed your heart skipping or missing a beat | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Heartburn or indigestion that is not related to eating | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Any other symptoms that you think may be related to heart or circulation problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you <i>currently</i> take medication for any of the following problems? | | |
| a. Breathing or lung problems | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Heart trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. If you have used a respirator, have you <i>ever had</i> any of the following problems? | | |
| <input type="checkbox"/> Check here if you've never used a respirator and move on to question 9. | | |
| a. Eye irritation | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Skin allergies or rashes | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| d. General weakness or fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Any other problem that interferes with your use of a respirator | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? | <input type="checkbox"/> | <input type="checkbox"/> |

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 is voluntary.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 10. Have you <i>ever lost</i> vision in either eye (temporarily or permanently) | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you <i>currently</i> have any of the following vision problems? | | |
| a. Wear contact lenses | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Wear glasses | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Color blind | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Any other eye or vision problem | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|---|--------------------------|--------------------------|
| 12. Have you <i>ever had</i> an injury to your ears, including a broken ear drum? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you <i>currently</i> have any of the following hearing problems? | | |
| a. Difficulty hearing | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Wear a hearing aid | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Any other hearing or ear problem | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you <i>ever had</i> a back injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you <i>currently</i> have any of the following musculoskeletal problems? | | |
| a. Weakness in any of your arms, hands, legs, or feet | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Back pain | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Difficulty fully moving your arms and legs | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Pain or stiffness when you lean forward or backward at the waist | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Difficulty fully moving your head up or down | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Difficulty fully moving your head side to side | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Difficulty bending at your knees | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Difficulty squatting to the ground | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Climbing a flight of stairs or a ladder carrying more than 25 lbs | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Any other muscle or skeletal problem that interferes with using a respirator | <input type="checkbox"/> | <input type="checkbox"/> |

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.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen? | <input type="checkbox"/> | <input type="checkbox"/> |
| If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you are working under these conditions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. At work or at home, have you ever been exposed to or come into skin contact with hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust)? | <input type="checkbox"/> | <input type="checkbox"/> |
| If "yes," name the chemicals if you know them: _____ | | |
| 3. Have you ever worked with any of the materials or under any of the conditions listed below: | | |
| a. Asbestos | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Silica (e.g., in sandblasting) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Tungsten/cobalt (e.g., grinding or welding this material) | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Beryllium | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Aluminum | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Coal (e.g., mining) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Iron | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Tin | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Dusty environments | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Any other hazardous exposures | <input type="checkbox"/> | <input type="checkbox"/> |
| If "yes," describe these exposures:

_____ | | |
| 4. List any second jobs or side businesses you have: _____ | | |
| 5. List your previous occupations: _____ | | |
| 6. List your current and previous hobbies: _____ | | |
| 7. Have you been in the military services? | <input type="checkbox"/> | <input type="checkbox"/> |
| If "yes," were you exposed to biological or chemical agents (either in training or combat) | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever worked on a HAZMAT team? | <input type="checkbox"/> | <input type="checkbox"/> |

	Yes	No
9. 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) If "yes," name the medications if you know them: _____	<input type="checkbox"/>	<input type="checkbox"/>
10. Will you be using any of the following items with your respirator(s)?		
a. HEPA Filters	<input type="checkbox"/>	<input type="checkbox"/>
b. Canisters (for example, gas masks)	<input type="checkbox"/>	<input type="checkbox"/>
c. Cartridges	<input type="checkbox"/>	<input type="checkbox"/>
11. How often are you expected to use the respirator(s) (check all that apply)?:		
<input type="checkbox"/> a. Escape only (no rescue)	<input type="checkbox"/> c. Less than 5 hours <i>per week</i>	<input type="checkbox"/> e. 2 to 4 hours per day
<input type="checkbox"/> b. Emergency rescue only	<input type="checkbox"/> d. Less than 2 hours <i>per day</i>	<input type="checkbox"/> f. Over 4 hours per day
12. During the period you are using the respirator(s), is your work effort:		
a. <i>Light</i> (less than 200 kcal per hour) Examples of a light work effort are <i>sitting</i> while writing, typing, drafting, or performing light assembly work; or <i>standing</i> while operating a drill press (1-3 lbs.) or controlling machines. If "yes," how long does this period last during the average shift: _____ hrs. _____ min.	<input type="checkbox"/>	<input type="checkbox"/>
b. <i>Moderate</i> (200 to 350 kcal per hour) Examples of moderate work effort are <i>sitting</i> while nailing or filing; <i>driving</i> a truck or bus in urban traffic; <i>standing</i> while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; <i>walking</i> on a level surface about 2 mph or down a 5-degree grade about 3 mph; or <i>pushing</i> 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: _____ hrs. ____ min.	<input type="checkbox"/>	<input type="checkbox"/>
c. <i>Heavy</i> (above 350 kcal per hour) Examples of heavy work are <i>lifting</i> a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; <i>shoveling</i> ; <i>standing</i> while bricklaying or chipping castings; <i>walking</i> 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: _____ hrs. _____ min.	<input type="checkbox"/>	<input type="checkbox"/>
13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you are using your respirator? If "yes," describe this protective clothing and/or equipment: _____	<input type="checkbox"/>	<input type="checkbox"/>
14. Will you be working under hot conditions (temperature exceeding 77°F)	<input type="checkbox"/>	<input type="checkbox"/>
15. Will you be working under humid conditions?	<input type="checkbox"/>	<input type="checkbox"/>
16. Describe the work you will be doing while you are using your respirator(s): _____		
17. Describe any special or hazardous conditions you might encounter when you are using your respirator(s) (for example, confined spaces, life threatening gases): _____		
18. Provide the following information, if you know it, for each toxic substance that you will be exposed to when you are using your respirator(s):		
Name of toxic substance: _____	Name of toxic substance: _____	
Estimated maximum exposure level per shift: _____	Estimated maximum exposure level per shift: _____	
Duration of exposure per shift: _____	Duration of exposure per shift: _____	
Name of toxic substance: _____	Name(s) of any other toxic substance(s) you will be exposed to while using your respirator(s): _____	
Estimated maximum exposure level per shift: _____		
Duration of exposure per shift: _____		
19. Describe any special responsibilities you will have while using your respirator(s) that may affect the safety and well being of others (for example, rescue, security): _____		