ExpressCare
Urgent Care Clinic
Walk-in Care + Occupational Medicine

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Original Date:	
Dates Revised:	

Company: _____

Can you read (circle one): YES / NO

OSHA Respirator Medical Evaluation Questionnaire

CFR App. C to 1910.137, January 8, 1998

Before you answer this questionnaire ask your employer to give you information on: type or respirators you will use, for how long (hours/day, times/week), under what conditions (temp., humidity), and type of physical effort and other protective gear you will wear. Examples of physical effort are given under pat B item 12, page 4 (a sample information form is given below).

Information on your work conditions (please mark as appropriate):

1. Type or respirator to be used	☐ Air Purifying	☐ Air Supplied	☐ Self-Contained	☐ Other
		Model & Series:		Weight:
2. Duration of work with respirators	Hours/day:	Days/week	Other:	
3. Expected physical work	☐ Light	☐ Moderate	☐ Heavy	☐ Other
4. Other additional protective gear or PPE you will wear:				
5. Working Conditions	Temperature:	Humidity	Other:	

*** Your employer must allow you to answer this questionnaire during normal working hours, or at a time or 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.***

***DO NOT FORGET TO SIGN BELOW THE STATEMENT SAYING THAT YOU HAVE ANSWERED THESE QUESTIONS TRUTHFULLY AT THE END OF THIS QUESTIONNAIRE**

ALL PARTS OF THIS QUESTIONNAIRE MUST BE ANSWERED. QUESTIONS 10-15 OF PART A SECTION 2 ARE TO BE ANSWERED ONLY BE EMPLOYEES WHO WILL USE *a full-face piece respirator or a self-contained breathing apparatus (SCBA).

Part A. Section 1: The following information must be provided by every employee who has been selected to use any type of respirator (please print and check YES / NO as necessary).

1. Today's Date:	**2. Your Name:**
3. Your Age:	**4. Sex:** ☐ M ☐ F
5. Your Height:	**6. Your Weight:**
7. Job Title:	

Please write your name here: _____

8. A phone number where you can be reached by the health care professional who reviews this questionnaire can reach you (include Area Code):		
9. Best time to call you at this number:		
10. Has your employer told you how to contact the person who will review this questionnaire?	☐ YES	☐ NO
11. 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)	
12. Have you worn a respirator?	☐ YES	☐ NO
If "yes", what types:		

VERY IMPORTANT: *If your answer is yes to any of the question concerning your health in this questionnaire, you must describe them in detail answering these questions: did you have the problem in the past or are you currently suffering from the problem? Is it under control now? Are you taking medications for it? Are you under a physician's supervision?*

Part A. Section 2: Questions 1 through 9 below 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 you smoked tobacco in the last month?	☐ YES	☐ NO
2. Have you ever had any of the following conditions?		
a. Seizures (fits)	☐ YES	☐ NO
b. Diabetes (sugar disease)	☐ YES	☐ NO
c. Allergic reactions that interfere with your breathing	☐ YES	☐ NO
d. Claustrophobia(fear of closed-in places)	☐ YES	☐ NO
e. Trouble smelling odors	☐ YES	☐ NO
If "YES" please explain in detail:		
3. Have you ever had any of the following pulmonary or lung problems?		
a. Asbestoses	☐ YES	☐ NO
b. Asthma	☐ YES	☐ NO
c. Emphysema	☐ YES	☐ NO
d. Pneumonia	☐ YES	☐ NO
e. Silicosis	☐ YES	☐ NO
f. Lung Cancer	☐ YES	☐ NO
g. Broken ribs	☐ YES	☐ NO
h. Tuberculosis	☐ YES	☐ NO
i. Pneumothorax (collapsed lung)	☐ YES	☐ NO
j. Chronic bronchitis	☐ YES	☐ NO
k. Any chest injuries or surgeries	☐ YES	☐ NO
l. Any other lung problems you had	☐ YES	☐ NO
If "YES" please explain in detail:		
4. Do you currently have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath	☐ YES	☐ NO
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐ YES	☐ NO
c. Shortness of breath when walking with other people at an ordinary pace on level ground	☐ YES	☐ NO
d. Have to stop for breath when walking at your own pace on level ground	☐ YES	☐ NO

Please write your name here: _____

e. Shortness of breath when washing or dressing yourself	☐ YES	☐ NO
f. Shortness of breath that interferes with your job	☐ YES	☐ NO
g. Coughing that produces phlegm (thick sputum)	☐ YES	☐ NO
h. Coughing that wakes you early in the morning	☐ YES	☐ NO
i. Coughing that occurs mostly when you are lying down	☐ YES	☐ NO
j. Coughing up blood in the past month	☐ YES	☐ NO
k. Wheezing	☐ YES	☐ NO
l. Wheezing that interferes with your job	☐ YES	☐ NO
m. Chest pain when you breathe deeply	☐ YES	☐ NO
n. Any other symptoms that you think may be related to lung problems	☐ YES	☐ NO
If "YES" please explain in detail:		
5. Have you ever had any of the following cardiovascular or heart problems?		
a. Heart attack	☐ YES	☐ NO
b. Stroke	☐ YES	☐ NO
c. Angina	☐ YES	☐ NO
d. Heart failure	☐ YES	☐ NO
e. Swelling in your legs or feet (not caused by walking)	☐ YES	☐ NO
f. Heart arrhythmia (heart beating irregularly)	☐ YES	☐ NO
g. High blood pressure	☐ YES	☐ NO
h. Any other heart problem that you've been told about	☐ YES	☐ NO
If "YES" please explain in detail:		
6. Have you ever had any of the following cardiovascular or heart symptoms?		
a. Frequent pain or tightness in your chest	☐ YES	☐ NO
b. Pain or tightness in your chest during physical activity	☐ YES	☐ NO
c. Pain or tightness in your chest that interferes with your job	☐ YES	☐ NO
d. In the past two years, have you noticed your heart skipping or missing a beat	☐ YES	☐ NO
e. Heartburn or indigestion that is not related to eating	☐ YES	☐ NO
f. Any other symptoms that you think may be related to heart or circulation problems	☐ YES	☐ NO
If "YES" please explain in detail:		
7. Do you currently take medication for any of the following problems?		
a. Breathing or lung problems	☐ YES	☐ NO
b. Heart trouble	☐ YES	☐ NO
c. Blood pressure	☐ YES	☐ NO
d. Seizures (fits)	☐ YES	☐ NO
If "YES" please explain in detail and list the name of medications:		
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) _____		
a. Eye irritation	☐ YES	☐ NO
b. Skin allergies or rashes	☐ YES	☐ NO
c. Any other problem that interferes with your use of a respirator:	☐ YES	☐ NO
d. General weakness or fatigue	☐ YES	☐ NO
e. Anxiety	☐ YES	☐ NO

Please write your name here: _____

If "YES" please explain in detail:		
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 employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). Those 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
If "YES" please explain in detail:		
11. Do you currently have any of the following vision problems?		
a. Wear contact lenses		
b. Wear glasses	☐ YES	☐ NO
c. Color blindness		
d. Any other eye or vision problems	☐ YES	☐ NO
If "YES" please explain in detail:		
12. Have you ever had an injury to your ears, including a broken ear drum?	☐ YES	☐ NO
If "YES" please explain in detail:		
13. Do you currently have any of the following hearing problems?		
a. Difficulty hearing	☐ YES	☐ NO
b. Wear a hearing aid	☐ YES	☐ NO
c. Any other hearing or ear problems	☐ YES	☐ NO
If "YES" please explain in detail:		
14. Have you ever had a back injury?	☐ YES	☐ NO
If "YES" please explain in detail:		
15. Do you currently have any of the following musculoskeletal problems?		
a. Weakness in any of your arms, hands, legs or feet	☐ YES	☐ NO
b. Back pain	☐ YES	☐ NO
c. Difficulty fully moving your arms or legs	☐ YES	☐ NO
d. Pain or stiffness when you lean forward or backward at the waist	☐ YES	☐ NO
e. Difficulty fully moving your head up or down	☐ YES	☐ NO
f. Difficulty fully moving your head side to side	☐ YES	☐ NO
g. Difficulty bending at your knees	☐ YES	☐ NO
h. Difficulty squatting to the ground	☐ YES	☐ NO
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.	☐ YES	☐ NO
j. Any other muscle or skeletal problem that interferes with using a respirator	☐ YES	☐ NO
If "YES" please explain in detail:		
Part B. Any of the following questions, and other questions not listed, maybe added to the questionnaire at the discretion of the health care professional who will review the questionnaire.		
1. In you present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen?	☐ YES	☐ NO

Please write your name here: _____

If "YES" do you have feeling of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions?	☐ YES	☐ NO
If "YES" please explain in detail:		
2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals?	☐ YES	☐ NO
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	☐ YES	☐ NO
b. Silica (e.g., in sandblasting)	☐ YES	☐ NO
c. Tungsten/cobalt	☐ YES	☐ NO
d. Beryllium	☐ YES	☐ NO
e. Aluminum	☐ YES	☐ NO
f. Coal	☐ YES	☐ NO
g. Iron	☐ YES	☐ NO
h. Tin	☐ YES	☐ NO
j. Any other hazardous exposure	☐ YES	☐ NO
If "YES" to question describe these exposures. Did you have any problems with these exposures? Were you cleared for work after these exposures? Please explain:		
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?	☐ YES	☐ NO
If "YES", were you exposed to biological or chemical agents (either in training or combat)?	☐ YES	☐ NO
If "YES", describe those exposures:		
10. Will you be using any of the following items with your respirator(s)?		
a. HEPA filters	☐ YES	☐ NO
b. Canisters (e.g., gas masks)	☐ YES	☐ NO
c. Cartridges	☐ YES	☐ NO
11. How often are you expected to use the respirator(s):		
a. Escape only (no rescue)	☐ YES	☐ NO
b. Emergency rescue only	☐ YES	☐ NO
c. Less than 5 hrs. per week	☐ YES	☐ NO
d. Less than 2 hrs. per day	☐ YES	☐ NO
e. 2 to 4 hrs. per day	☐ YES	☐ NO
f. Over 4 hrs. per day	☐ YES	☐ NO
12. During the period you are using the respirator(s), is your work effort:		
a. Light(less than 200 kcal per hour) *Examples of light work effort are sitting while writing, typing, drafting, or preforming light assembly work or standing while operating a drill press (1-3 lbs.) or controlling machines.*	☐ YES	☐ NO
b. Moderate (200 to 350 kcal per hour)	☐ YES	☐ NO

Please write your name here: _____

Examples of moderate work effort are sitting while nailing or filing; diving a truck or bus in urban traffic, standing while nailing, drilling, performing assembly work, or transferring a moderate load (about 35 lbs.) at true level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.		
c. Heavy (about 350 kcal per hour) *Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or should; 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.)*	☐ YES	☐ NO
13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator?	☐ YES	☐ NO
If "YES" describe this clothing and/or equipment:		
14. Will you be working under hot conditions (temperature exceeding 77 degrees F)	☐ YES	☐ NO
15. Will you be working under humid conditions	☐ YES	☐ NO
16. Describe the work you'll will be doing while you're using your respirator(s):		
17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (e.g., confined spaces, life threatening gases:		
18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):		
Name of first toxic substance:		
Estimated maximum exposure level per shift:		
Duration of exposure per shift:		
Name of second toxic substance:		
Estimated maximum exposure level per shift:		
Duration of exposure per shift:		
Name of third toxic substance:		
Estimated maximum exposure level per shift:		
Duration of exposure per shift:		
Name any other toxic substances that you'll be exposed to while using your respirator:		
19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (e.g., rescue, security)		

NOW PLEASE GO BACK TO EACH PAGE AND SEE IF YOU HAVE ANSWERED ALL THE QUESTIONS

Employee Acknowledgment (YOU MUST READ and SIGN THIS STATEMENT)

I understand that not answering the above questions truthfully can threaten the safety of myself and others. Therefore, I hereby certify that to the best of my knowledge the answers I gave to the above questions on pages 1-4 are correct and I understand that any false statement or incorrect information may result in my termination and may forfeit my right to worker's compensation benefits under R.S. 23:1207.1

Employee Name: _____ **S.S. #**: _____

Employee Signature: _____ **Date**: _____

Evaluation/Notes by health care professional who will review this questionnaire:

Please write your name here: _____

☐ No medical conditions were found/detected which can prevent the employee from using respiratory protection as described

☐ Medical conditions were found which can prevent the employee from routine use of respiratory protection

☐ Medical conditions allow only for escape route or emergency use of respirators

☐ Medical evaluation is necessary before routine use of respiratory protection

_____
_____
_____
_____
_____
_____

If Respirator fit test is done, please fill out the following part:

Type of Mask fitted & Manufacturer	Size	Fit Factor
1.		
2.		
3.		

Other Tests

_____ _____

Technician Signature **Date**