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OSHA Respirator Medical Evaluation Questionnaire

WorkHealth Use Only Contact Attempts: _____ _____ _____	Review Date: _____ Reviewer: _____ <input type="checkbox"/> Cleared for Fit Testing <input type="checkbox"/> Requires Respirator Physical
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Employer Information: **Employer or Employee must complete**

Name of Employer: **Ohio Department of Natural Resources**

Division: (Please check one) **Forestry** **Parks** **Wildlife**

Phone: _____ Fax: _____

Please Fax completed questionnaire to WorkHealth @ 614-533-0043

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

1. Today's Date: _____
2. Your Name: _____
3. Your Age: _____ Date of Birth: _____
4. Sex (Check one): Male Female
5. Your height: _____ ft. _____ in.
6. Your weight: _____ lbs.
7. Your job title: _____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the AREA CODE): _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire? **Yes** **No**
11. Check the type of respirator you will use (you may 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-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator? **Yes** **No**
 If "yes", what type(s): _____

Every employee who has been selected to use any type of respirator must answer questions 1 through 9 below.

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month? Yes No
- a. How long have you smoked? ____ (years) ____ (months)
b. How much? _____ packs/day and or _____ cigarettes/day
2. Have you **ever had** any of the following conditions? Yes No
- a. Seizures Yes No
- 1) Are you taking medication? _____
2) When was your last seizure? _____
- b. Diabetes (sugar disease) Yes No
- 1) Are you taking medication (oral or shot)? _____ Yes No
2) Do you have regular physician visits? _____ Yes No
3) When was your last visit with your doctor? _____
4) Has your blood sugar been in the normal range? Yes No
- c. Allergic reactions that interfere with your breathing? Yes No
- d. Claustrophobia (fear of closed-in places)? Yes No
- e. Any problems when wearing a respirator? Yes No
- f. Trouble smelling odors? Yes No
What difficulty? _____
3. Have you **ever had** any of the following pulmonary or lung problems? Yes No
- a. Asbestosis Yes No
If yes, when (year) _____, any complications? _____
- b. Asthma: Yes No
If yes, when (year) _____, any complications? _____
- c. Chronic bronchitis: Yes No
If yes, when (year) _____, any complications? _____
- d. Emphysema: Yes No
If yes, when (year) _____, any complications? _____
- e. Pneumonia: Yes No
If yes, when (year) _____, any complications? _____
- f. Tuberculosis: Yes No
If yes, when (year) _____, any complications? _____
- g. Silicosis: Yes No
If yes, when (year) _____, any complications? _____
- h. Pneumothorax (collapsed lung): Yes No
If yes, when (year) _____, any complications? _____
- i. Lung cancer: Yes No
If yes, when (year) _____, any complications? _____

- j. Broken ribs: Yes No
If yes, when (year) _____, any complications? _____
- k. Any chest injuries or surgeries: Yes No
If yes, when (year) _____, any complications? _____
- l. Any other lung problem that you've been told about: Yes No
Describe: _____

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

- 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
- 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 last 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

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

- a. Heart attack: If yes, when (year) _____ Yes No
- b. Stroke: If yes, when (year) _____ Yes No
- c. Angina: If yes, when (year) _____ Yes No
- d. Heart failure: If yes, when (year) _____ Yes No
- e. Swelling in your legs or feet (not caused by walking): Yes No
If yes, when (year) _____
- f. Heart arrhythmia (heart beating irregularly): Yes No
If yes, when (year) _____

g. High blood pressure: Yes No
If yes, when (year) _____

h. Any other heart problem that you've been told about: Yes No
If yes, when (year) _____

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

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 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?

a. Breathing or lung problems: Yes No
1) Medication(s) _____

b. Heart trouble: Yes No
1) Medication(s) _____
2) Heart condition _____

c. Blood pressure: Yes No
1) Medication(s) _____
2) How long have you been taking B/P medication? _____
3) Is your blood pressure controlled? Yes No
4) Do you have regular check-ups with your family doctor? Yes No

8. If you've used a respirator, have you ever had any of the following problems?

a. Eye irritation: Yes No
If yes, describe: _____

b. Skin allergies or rashes: Yes No
If yes, describe: _____

c. Anxiety: Yes No
If yes, describe: _____

d. General weakness or fatigue: Yes No
If yes, describe: _____

e. Any other problem that interferes with your use of a respirator: Yes No
If yes, describe: _____

9. Would you like to talk to the healthcare professional who will review this questionnaire about our 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-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.

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?
- a. Wear contact lenses: **Yes** **No**
 - b. Wear glasses: **Yes** **No**
 - c. Color blind: **Yes** **No**
 - d. 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? **Yes** **No**
- a. Difficulty hearing: **Yes** **No**
 - b. Wear a hearing aid: **Yes** **No**
 - c. 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?
- a. Weakness in any of your arms, hands, legs, or feet: **Yes** **No**
 - b. Back pain: **Yes** **No**
 - c. Difficulty fully moving your arms and 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 from side to side: **Yes** **No**
 - g. Difficulty bending at the 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:
Describe: _____ **Yes** **No**