

# Prince William) HOSPITAL

## OCCUPATIONAL HEALTH

### OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

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 (Circle One): Yes/No

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.)

1. Today's date: \_\_\_\_\_
2. Name: \_\_\_\_\_
3. Age: \_\_\_\_\_
4. Sex (circle one): Male/Female
5. Ht. \_\_\_\_\_ ft. \_\_\_\_\_ in. \_\_\_\_\_
6. Weight: \_\_\_\_\_ lbs.
7. Your job title: \_\_\_\_\_
8. A phone number where you can be reached by the healthcare professional who reviews this questionnaire (include area code): \_\_\_\_\_
9. The best time to phone you at this number: \_\_\_\_\_
10. Has your employer told you how to contact the healthcare professional who will review this questionnaire?  
Yes/No
11. 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).
12. Have you worn a respirator (circle one): Yes/No  
If "Yes" what type(s): \_\_\_\_\_

Part A. Section 2. (Mandatory) Questions 1-9 below must be answered by every employee who has been selected to use any type of respirator (please circle "Yes" or "No").

1. Do you *currently* smoke tobacco, or have you smoked 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

- 3. Have you ever had any of the following pulmonary or lung problems?** Yes/No
- |                        |        |                                     |        |
|------------------------|--------|-------------------------------------|--------|
| a. Asbestosis:         | Yes/No | h. Pneumothorax (collapsed lung):   | Yes/No |
| b. Asthma:             | Yes/No | i. Lung cancer:                     | Yes/No |
| c. Chronic bronchitis: | Yes/No | j. Broken ribs:                     | Yes/No |
| d. Emphysema:          | Yes/No | k. Any chest injuries or surgeries: | Yes/No |
| e. Pneumonia:          | Yes/No | l. Any other lung problem           |        |
| f. Tuberculosis:       | Yes/No | you have been told about:           | Yes/No |
| g. Silicosis:          | Yes/No |                                     |        |
- 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:      | 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:  | 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 |
- 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 |
- 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:                   | 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:) Have never used a respirator \_\_\_\_\_
- a. Eye irritation: Yes/No
  - b. Skin allergies or rashes: Yes/No
  - c. Anxiety: Yes/No
  - d. General weakness or fatigue: Yes/No
  - e. Any other problem that interferes with your use of a respirator: Yes/No
9. Would you like to talk to the healthcare professional who will review this questionnaire about your answers: 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). 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:
- 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 head up or down: Yes/No
  - d. Pain or stiffness when you lean forward or backward at the waist: Yes/No
  - e. Difficulty fully moving your arms or legs: Yes/No
  - f. Difficulty bending at your knees: Yes/No
  - g. Difficulty squatting to the ground: Yes/No
  - h. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes/No
  - i. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_