Weisman Children's

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

CFR 1910.134

To the Employee:

Can you read: ☐ Yes ☐ No

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, only the Infection Control/Employee Health Practitioner will have access to review your answers to this questionnaire. This questionnaire will remain as a permanent part of your medical record.

NAME:_____ DATE:_____

EMPLOYER:_____ JOB TITLE:_____

HEIGHT:_____ WEIGHT:_____ AGE:_____ SEX: M / F

PHONE:_____

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 (e.g., Half or full facepiece type, powered air purifying, supplied air, self-contained breathing apparatus).

Have you worn a respirator? ☐ Yes ☐ No

If "yes" what type(s): _____

Questions 1 through 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 tobacco in the last month? YES / NO

2. Have you ever had any of the following conditions?
   - A. Seizures 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?
   - A. Asbestosis YES / NO
   - B. Asthma YES / NO
   - C. Chronic bronchitis YES / NO
   - D. Emphysema YES / NO
   - E. Pneumonia YES / NO
   - F. Tuberculosis YES / NO
   - G. Silicosis YES / NO
   - H. Pneumothorax (collapsed lung) YES / NO
   - I. Lung cancer YES / NO
   - J. Broken ribs YES / NO
   - K. Any chest injuries or surgeries YES / NO
   - L. Any other lung problem that you've been told about YES / NO

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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 place 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 my 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 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 never used a respirator, check the following space and go on to question 9)
   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 a health care professional who will review this questionnaire & discuss 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 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 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? YES / NO
    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 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 25lbs. YES / NO
    J. Any other muscle or skeletal problem that interferes with using a respirator YES / NO

16. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g. gases, fumes or dust) or have your come into skin contact with hazardous chemicals? YES / NO

17. 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/Cobolt (e.g., grinding or welding this material) YES / NO
    D. Benyllium YES / NO
    E. Aluminum YES / NO
    F. Coal (e.g., mining) YES / NO
    G. Iron YES / NO
    H. Tin YES / NO
    I. Dusty Environments YES / NO
    J. Any other hazardous exposures YES / NO
    If yes, describe these exposures:_____

18. 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)? YES / NO
    If "yes" name the medications if you know them: _____

All of the above information is true to the best of my knowledge and belief. I understand that I am required to update the information as I become aware of any new information.

_____ _____
Signature Date