Nevada Occupational HEALTH & INJURY CARE CENTER

EMPLOYEE OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Employee:____ **Date of Birth:**____

Address: ____ **Contact phone:** ____

Company / Employer : ____

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.

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).

Can you read? (Circle one) Yes No

1. Your height: _________ft. _________ in.
2. Your weight: _________lbs.
3. Your job title: ____
4. A phone number where you can be reached by the health care professional who will review this questionnaire (include area code): _____________________________________
5. The best time to phone you at this number is: ______am/ ______pm.
6. Has your employer told you how to contact the health care professional who will review this questionnaire? (circle one): Yes No
7. 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-facepiece type, powered -air purifying, supplied - air, self-contained breathing apparatus).
8. Have you worn a respirator (circle one): Yes No
   If "Yes", what type(s): ____

PART A SECTION 2 (MANDATORY)

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?
   Yes No 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

3. Have you ever had any of the following pulmonary or lung problems?

Yes No 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

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

Yes No a. Shortness of breath
Yes No b. Shortness of breath when walking 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

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

Yes No 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
Yes No g. High blood pressure
Yes No h. Any other heart problem that you've been told about

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

Yes No 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 might be related to heart or circulation problems

7. Do you currently take medication for any of the following problems?

Yes No a. Breathing or lung problems
Yes No b. Heart trouble
Yes No c. Blood pressure
Yes No d. Seizures (fits)

8. If you've never used a respirator, check the following space and go to question 9 ☐. If you've used a respirator, have you ever had any of the following problems?

Yes No 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 problems that interfere with your use of a respirator?

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-facepiece respirator or 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?
    Yes No a. Wear contact lenses
    Yes No b. Wear glasses
    Yes No c. Color blindness
    Yes No d. Any other eye or vision problems

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 aide
    Yes No c. Any other hearing or ear problems

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 25 lbs.
    Yes No j. Any other muscle or skeletal problem that interferes with using a respirator.

____________________________________ ____________________________________
Employee Signature (When Available) Date

Employee:____ **Date of Birth:**____

Address: ____ **Contact phone:** ____

Company / Employer : ____

PROVIDER / PHYSICIAN SECTION

___I have reviewed Part A Section 2 of this questionnaire **with** the employee and **I do not recommend** that a physical examination be performed.

___I have reviewed Part A Section 2 of this questionnaire **with** the employee and **I am recommending** that a physical examination be performed.

___I have reviewed Part A section 2 of this questionnaire **without** the employee and **I do not recommend** that a physical examination be performed.

___I have reviewed Part A Section 2 of this question **without** the employee and **I am recommending** that a physical examination be performed.

_________________________________ _________________________________
Provider / Physician Signature Date