OSHA Respirator Medical Evaluation Questionnaire

MANDATORY

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

Today’s Date_________________

Your Name: ______________________________ Your age: ______________ (to nearest year)

Sex (circle one): Male Female Your height: __ __ft. ___ __n. Your weight: ______lb.

Your job title: ______________________________

Phone number where you can be reached by the health care professional who reviews this questionnaire (include area code): ______________________________

The best time to phone you at this number: ________________ __________

Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes No

1. 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)

   __X Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

2. Have you worn a respirator (circle one): Yes No  If “yes,” what type(s)?:

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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?
   a. Seizures (fits): Yes No
   b. Diabetes (sugar disease): Yes No
   c. Allergic reactions that interfere with your breathing: Yes No
da. Claustrophobia (fear of closed-in places): Yes No
e. Trouble smelling odors: Yes No

3. Have you ever had any of the following pulmonary of lung problems?
   a. Asbestosis: Yes No
   b. Asthma: Yes No
c. Chronic bronchitis:
   d. Emphysema: Yes No
e. Pneumonia:
f. Tuberculosis: Yes No
g. Silicosis: Yes No
   h. Pneumothorax (collapsed lung):
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

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
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:
   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 (fits):  

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):  

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 health care professional who will review this questionnaire about your answers to this questionnaire?  

Yes  No

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OSHA Respirator Medical Evaluation Questionnaire
SCBA Questions

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?
   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 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 lb.: Yes No
   j. Any other muscle or skeletal problem that interferes with using a respirator: Yes No

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Part B. Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5000 feet) or in a place that has lower than normal amounts of oxygen: Yes No

   If “yes”, do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you’re working under these conditions: Yes No

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 (e.g., grinding or welding this material): Yes No
   d. Beryllium: Yes No
   e. Aluminum: Yes No
   f. Coal (for example, 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:

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

8. Have you ever worked on a HAZMAT team?  
   Yes  No

9. 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

10. Will you be using any of the following items with your respirator(s)?
    a. HEPA Filters:  
       Yes  No
    b. Canisters (for example, gas masks):  
       Yes  No
    c. Cartridges:  
       Yes  No

11. How often are you expected to use the respirator(s) (circle “yes” or “no” for all answers that apply to you):
    a. Escape only (no rescue):  
       Yes  No
    b. Emergency rescue only:  
       Yes  No
    c. Less than 5 hours per week:  
       Yes  No
    d. Less than 2 hours per day:  
       Yes  No
    e. 2 to 4 hours per day:  
       Yes  No
    f. Over 4 hours 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):  
       Yes  No
       If “yes”, how long does this period last during the average shift: _____hr. _____min
       
       Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lb..) or controlling machines.

    b. Moderate (200-300 kcal per hour):  
       Yes  No
       If “yes”, how long does this period last during the average shift: _____hr. _____min

       Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lb..) at trunk 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 lb..) on a level surface.

    c. Heavy (above 350 kcal per hour):  
       Yes  No
       If “yes”, how long does this period last during the average shift: _____hr. 45 min

       Examples of heavy work are lifting a heavy load (about 50 lb..) from the floor to your waist or shoulder; 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 lb..).

13. Will you be wearing clothing and/or equipment (other than the respirator) when you’re using your respirator:  
   Yes  No

   If “yes”, describe this protective clothing and/or equipment:
14. Will you be working under hot conditions (temperatures exceeding 77° F.): Yes No

15. Will you be working under humid conditions: Yes No

16. Describe the work you’ll 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) (for example, confined spaces, life-threatening gases): IDLH Conditions, Confined Spaces, Radioactive Exposure, Trip/slip/fall hazardous due to limited visibility.

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 the first toxic substance:
   Estimated maximum exposure level per shift:
   Duration of exposure per shift:

   Name of the second toxic substance:
   Estimated maximum exposure level per shift:
   Duration of exposure per shift:

   Name of the third toxic substance:
   Estimated maximum exposure level per shift:
   Duration of exposure per shift:

   The name of 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 (for example, rescue, security): Rescue, Patching/Plugging leaks, and other forms of controlling a chemical leak.

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Employer Questionnaire

Employer Name: _______ County of York, Hazardous Materials Team ________________

Address: _______ 120 Davies Dr. __________________________________________________________________________

City: _______ York ______________ State: _PA_ Zip Code: __17402________

Contact Person: _______ Thomas Graybill Jr., HazMat 91 Administrator ______________

Phone Number: ____717-840-2913_____________ FAX number: _____717-840-7406_

Date: ______________________

The following information must be provided to WORKFIRST before the health care provider makes a recommendation concerning an employee’s ability to use a respirator:

A. The type and weight of the respirator to be used by the employee:

MSA, 60 minute, Self Contained Breathing Apparatus. Weight 40 Lbs

B. The duration and frequency of respirator use (including use for rescue and escape):

Bottles are 60 minutes. Our Procedure allows for 20 minutes to get in, 20 minutes to do necessary work and 20 minutes to get out and THROUGH decon. Time is controlled by “Entrance and Safety Officers”.

C. The expected physical work effort:

Should be 20 minutes of heavy work, in SCBA and Level “A” totally encapsulated suit.

D. Additional protective clothing and equipment to be worn:

General entrance to hazmat area, Level “A” encapsulated suit.

E. Temperature and humidity extremes that may be encountered:

Workers could encounter average temperature and humidity of the area, and time of year. There are also facilities which have extremes in cold as in cold storage facilities and heat as in proximity of enclosed areas in summer.

Please attach a list of employees to whom the respirator information on this page pertains.

The employer shall also provide WORKFIRST with a copy of the written respiratory protection program.