Occucare INTERNATIONAL

OSHA Respirator Medical Evaluation Questionnaire (Mandatory per 29 CFR 1910.134)

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: Company: _____

Can you read (circle one): 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. (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. Your name:_____
3. Home Address, City, ST, Zip: _____
4. Social Security # _____ (Must provide at least last 4)
5. Your age (to nearest year):_____
6. Sex (circle one): Male/Female
7. Your height: _____ ft. _____ in.
8. Your weight: _____ lbs.
9. Your job title:_____
10. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____
11. The best time to phone you at this number: _____
12. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes No
13. Check the type of respirator you will use (you can check more than one category):
    a. _____ N-95, R, or P-100 disposable respirator (filter-mask, non- cartridge type only).
    b. _____ Other type (for example powered-air purifying respirator - PAPR).
14. Have you worn a respirator (circle one): Yes No

If "yes," what type(s):_____

15. Have you had any significant changes in your health in the past year (respiratory, cardiac, etc.)? Yes No

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
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

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 flat ground or up a slight hill or incline:	Yes	No
c.	Shortness of breath when walking 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 (irregular heartbeat):	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/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, skip 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. Do you have any questions about the respiratory questionnaire and/or the program, and would you like to talk to the health care professional who will review 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?

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

If yes please specify:

a.	Diagnosed and documented by a physician, no care needed	Yes	No
b.	Diagnosed and documented by a medical professional, still under care	Yes	No
c.	Surgically repaired, no pain or complications	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 lbs:	Yes	No
j.	Any other muscle or skeletal problem that interferes with using a respirator:	Yes	No