OSHA Respiratory Medical Evaluation Questionnaire

To the Employer: Answers to questions in Sections A and B do not require a medical examination.

To the Employee: Can you read this questionnaire? ◯ **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.

SECTION A. PERSONAL INFORMATION

Name (Last, First, MI) | **Sex:** ◯ **M** ◯ **F** | **Date of Birth** | **Today's Date**

Height (**ft.** **in.**) | **Weight (lbs.)** | **Employer:** ◯ **BU** ◯ **BMC** | **Employee ID #** | **Dept**

Job Title | **Work Phone** | **Cell Phone** | **Email**

Phone number where you can be reached by the health care professional who reviews this questionnaire.

Best time to reach you at this phone number?

YES	NO	
◯	◯	Has your employer told you how to contact the health care professional who will review this questionnaire?
◯	◯	Does this position require the use of a respirator? If 'YES,' please identify type(s) of respirator below. ☐ N, R, or P Disposable Respirator (filter mask, non-cartridge type only) ☐ Other Type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, or self-contained breathing apparatus)
◯	◯	Have you ever worn a respirator? If 'YES,' please identify the type(s) of respirator used below.

SECTION B. MANDATORY INFORMATION (REQUIRED FOR ANYONE SELECTED TO WEAR ANY TYPE OF RESPIRATOR)

YES	NO	
◯	◯	1. **Do you currently smoke tobacco?**
◯	◯	2. **Have you smoked tobacco at any time during the past 30 days?**
		3. **Have you ever had any of the following conditions?**
◯	◯	Seizures (fits or convulsions)?
◯	◯	Diabetes (sugar disease)?
◯	◯	Allergic reactions that interfere with your breathing?
◯	◯	Claustrophobia (fear of closed-in places)?
◯	◯	Difficulty smelling odors?
		4. **Have you ever had any of the following pulmonary or lung problems?**
◯	◯	Asbestosis?
◯	◯	Asthma?
◯	◯	Chronic bronchitis?
◯	◯	Emphysema?

YES	NO	
		continued **4. Have you ever had any of the following pulmonary or lung problems?**
○	○	Pneumonia?
○	○	Tuberculosis?
○	○	Silicosis?
○	○	Pneumothorax (collapsed lung)?
○	○	Lung cancer?
○	○	Broken ribs?
○	○	Any chest injuries or surgeries?
○	○	Any other lung problems that you are aware of? If 'YES,' please identify below.

YES	NO	
		5. Do you currently have any of the following symptoms of pulmonary or lung illness?
○	○	Shortness of breath?
○	○	Shortness of breath when walking fast on a level ground or up a slight hill or incline?
○	○	Shortness of breath when walking with others at an ordinary pace on level ground?
○	○	Have to stop for breath when walking at your own pace on level ground?
○	○	Shortness of breath when washing or dressing yourself?
○	○	Shortness of breath that interferes with your job?
○	○	Coughing that produces phlegm (thick sputum)?
○	○	Coughing that wakes you early in the morning?
○	○	Coughing that occurs mostly when you are lying down?
○	○	Coughing up blood in the last month?
○	○	Wheezing?
○	○	Wheezing that interferes with your job?
○	○	Chest pain when you breathe deeply?
○	○	Any other symptoms you think may be related to lung problems? If 'YES,' please identify below.

YES	NO	
		6. Have you ever had any of the following cardiovascular or heart problems?
○	○	Heart attack?
○	○	Stroke?
○	○	Angina?
○	○	Heart failure?
○	○	Swelling in your legs or feet (not caused by walking)?
○	○	Heart arrhythmia (heart beating irregularly)?
○	○	High blood pressure?
○	○	Any other heart problem that you've been told about? If 'YES,' please identify below.

YES	NO	
		7. Have you ever had any of the following cardiovascular or heart-related symptoms?
○	○	Frequent pain or tightness in your chest?
○	○	Pain or tightness in your chest during physical activity?

YES	NO	
		continued 7. **Have you ever had any of the following cardiovascular or heart-related symptoms?**
○	○	Pain or tightness in your chest that interferes with your job?
○	○	In the past two years, have you noticed your heart skipping or missing a beat?
○	○	Heartburn or indigestion that is not related to eating?
○	○	Any other symptoms that you think may be related to heart or circulation problems? If 'YES,' please identify below.
YES	NO	8. **Do you currently take medication for any of the following problems?**
○	○	Breathing or lung problems?
○	○	Heart trouble?
○	○	Blood pressure?
○	○	Seizures (fits or convulsions)?
YES	NO	9. **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 box and go directly to question 10.) ☐
○	○	Eye irritation?
○	○	Skin allergies or rashes?
○	○	Anxiety?
○	○	General weakness or fatigue?
○	○	Any other problem that interferes with your use of a respirator?
○	○	10. **Would you like to talk to the health care professional who will review your answers to this questionnaire?**

SECTION C. MANDATORY INFORMATION

(Required for anyone selected to wear full-facepiece respirator or self-contained breathing apparatus [SCBA]. For anyone selected to wear other respirator types, answers to these questions are voluntary.)

YES	NO	
○	○	1. **Have you ever lost vision in either eye (temporarily or permanently)?**
		2. **Do you currently take medication for any of the following problems?**
○	○	Wear contact lenses?
○	○	Wear glasses?
○	○	Color blindness?
○	○	Any other eye or vision problem? If 'YES', please identify below.
○	○	3. **Have you ever had an injury to your ears, including a broken eardrum?**
		4. **Do you currently have any of the following hearing problems?**
○	○	Difficulty hearing?
○	○	Wear a hearing aid?
○	○	Any other hearing or ear problem?
○	○	Any other ear or hearing problem? If 'YES,' please identify below.
○	○	5. **Have you ever had a back injury?**

YES	NO	
		6. Do you currently have any of the following musculoskeletal problems?
○	○	Weakness in any of your arms, hands, legs, or feet?
○	○	Back pain?
○	○	Difficulty fully moving your arms and legs?
○	○	Pain or stiffness when you lean forward or backward at the waist?
○	○	Difficulty fully moving your head up or down?
○	○	Difficulty fully moving your head from side to side?
○	○	Difficulty bending at your knees?
○	○	Difficulty squatting to the ground?
○	○	Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs?
○	○	Any other muscular or skeletal problems that interfere with using a respirator? If 'YES,' please identify below.

SECTION D. OTHER REQUIRED INFORMATION

YES	NO	
○	○	**1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen? If 'YES,' do you experience any of the following when working under these conditions?** ☐ Dizziness ☐ Shortness of breath ☐ Pounding in chest ☐ Other, please identify below
○	○	**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? If 'YES,' please identify the names of the hazardous substances below.**
		3. Have you ever worked with any of the materials, or under any of the conditions, listed below?
○	○	Asbestos?
○	○	Silica (e.g., in sandblasting)?
○	○	Tungsten/cobalt (e.g., grinding or welding this material)?
○	○	Beryllium?
○	○	Aluminum?
○	○	Coal (for example, mining)?
○	○	Iron?
○	○	Tin?
○	○	Dusty environments?
○	○	Any other hazardous exposures? If 'YES,' please identify the exposures below.

4. Please list any second jobs or side businesses, previous occupations, and hobbies.

Second Jobs or Side Businesses	Previous Occupations	Hobbies

YES	NO	
○	○	**5. Have you ever been in the military services? If 'YES,' please respond to question 6. If 'NO,' skip to question 7.**
○	○	**6. If you answered 'YES' to question 5, were you ever exposed to biological or chemical agents in training or combat?**
○	○	**7. Have you ever worked on a HAZMAT team?**
○	○	**8. 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)? If 'YES,' please provide the type, dosage, frequency, and purpose below.**

Medication	Dosage	Frequency	Purpose

YES	NO	
		9. Will you be using any of the following items with your respirator(s)?
○	○	HEPA filters?
○	○	Canisters (for example, gas masks)?
○	○	Cartridges?
YES	NO	**10. How often are you expected to use the respirator(s)? Check the 'YES' or 'NO' boxes that apply to you.**
○	○	Escape only (no rescue)?
○	○	Emergency rescue only?
○	○	Less than 5 hours per week?
○	○	Less than 2 hours per day?
○	○	2 to 4 hours per day?
○	○	Over 4 hours per day?

11. During the period you are using the respirator(s), please classify your work effort from one of the following selections and provide the average duration for respirator use in hours and minutes below.

☐ **Light (less than 200 kcal per hr)**

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 lbs.) or controlling machines.

Avg Duration: _____ **hrs** _____ **mins**

☐ **Moderate (200 to 350 kcal per hr)**

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 lbs.) 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 lbs.) on a level surface.

Avg Duration: _____ **hrs** _____ **mins**

☐ **Heavy (more than 350 kcal per hr)**

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

Avg Duration: _____ **hrs** _____ **mins**

YES	NO	
○	○	**12. Will you be wearing protective clothing and/or equipment (other than the respirator) when using your respirator? If 'YES,' please describe the protective clothing and/or equipment.**
○	○	**13. Will you be working under hot conditions (temperatures exceeding 77 degrees Fahrenheit)?**
○	○	**14. Will you be working under humid conditions?**

15. Describe the work you will be doing while you are using your respirator(s).

16. **Describe any special or hazardous conditions you might encounter when using your respirator(s) (e.g., confined spaces, life-threatening gases, etc.).**

17. **Provide the following information, if you know it, for each toxic substance you will be exposed to when using your respirator(s).**

Toxic Substance	Estimated Maximum Exposure per Shift	Duration of Exposure per Shift

18. **Describe any special responsibilities you will have while using your respirator(s) that may affect the safety and well-being of others (e.g., rescue, security):**

SIGNATURE

My signature below indicates that I understand and agree with this information and that I have answered the questions to the best of my ability.

Employee Signature
If submitting electronically, type /s/ as a prefix to your typed name above

Date

FOR USE BY ROHP PERSONNEL ONLY

Reviewed by

Date

Determination:

- ☐ Cleared for unlimited respirator use
- ☐ Cleared with the following restrictions
- ☐ Pending additional medical information
- ☐ Not medically cleared to work with a respirator (the employee has a medical condition that would place him/her at increased risk of material health impairment from respirator exposure and/or respirator use).
- ☐ ROHP Opinion completed and distributed to supervisor/manager and EHS.

Notes: