NRAO Department of Environmental Safety & Security
Respirator Medical Evaluation Questionnaire Form

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

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:

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. Your age (to nearest year): _____

4. Sex (check one): Male_____ Female _____

5. Your height: _____ ft. _____ in.

6. Your weight: _____ lbs.

7. Your job title: _____

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____

9. The best time to phone you at this number: _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire (check one): Yes_____ No _____

11. 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).

12. Have you worn a respirator (check 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 check "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 _____

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: 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 (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 _____

d. 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'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 _____

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 lbs: Yes _____ No _____

j. Any other muscle or skeletal problem that interferes with using a respirator: Yes _____No _____

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 5,000 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 _____

If "yes," were you exposed to biological or chemical agents (either in training or combat): 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 _____

If "yes," name the medications if you know them:_____

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) (Check "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:_____ hrs. _____ mins.

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.

b. *Moderate* (200 to 350 kcal per hour): Yes _____No _____

If "yes," how long does this period last during the average shift:_____ hrs._____ mins.

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. c. *Heavy* (above 350 kcal per hour): Yes _____No _____

If "yes," how long does this period last during the average shift:_____ hrs._____ mins.

Examples of heavy work are *lifting* a heavy load (about 50 lbs.) 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 lbs.).

13. Will you be wearing protective 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 (temperature exceeding 77 deg. 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):

_____

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):

_____