

# RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

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**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 your answers. Your employer must tell you how to send or deliver this questionnaire to the health care professional who will review it.

**Part A. Section 1. Every employee selected to use any type of respirator must provide the following information (please print).**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: M / F Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Phone #: (     ) \_\_\_\_\_ - \_\_\_\_\_

A phone number where the health care professional can reach you (include the 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

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-face type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Have you worn a respirator (circle one)? Yes / No

If "yes", what type(s): \_\_\_\_\_

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# RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

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**Part A. Section 2. Every employee selected to use any type of respirator must answer questions 1 through 9 below (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. Silicosis Yes / No
    - c. Asthma Yes / No
    - d. Pneumothorax (collapsed lung) Yes / No
    - e. Chronic bronchitis Yes / No
    - f. Lung cancer Yes / No
    - g. Emphysema Yes / No
    - h. Broken ribs Yes / No
    - i. Pneumonia Yes / No
    - j. Any chest injuries or surgeries Yes / No
    - k. Tuberculosis Yes / No
    - l. Any other lung problem that you have 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 breath deeply Yes / No
    - n. Any other symptoms that you think may be related to lung problems Yes / No
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# RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

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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 problems that you have 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 2 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 have used a respirator, have you *ever* had any of the following problems? (If you have *never* used a respirator continue 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 discuss your answers with the health care professional who will review this questionnaire? Yes / No

**Employees who will use either a full-face respirator OR a self-contained breathing apparatus (SCBA) MUST answer Questions 10 through 15:**

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
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# RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

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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 pounds Yes / No
  - j. Any other muscle or skeletal problem that interferes with using a respirator Yes / No

**Part B. Section 1. The health care professional who will review this questionnaire may – at their discretion – add these questions and any other questions pertinent to this evaluation.**

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 are working under these condition? 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. Coal (for example, mining) Yes / No
  - c. Silica (e.g., sandblasting) Yes / No
  - d. Iron Yes / No
  - e. Tungsten/cobalt (grinding or welding this material) Yes / No
  - f. Tin Yes / No
  - g. Dusty environments Yes / No
  - h. Beryllium Yes / No
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# RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

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- i. Any other hazardous exposures Yes / No  
j. Aluminum 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. Were you ever 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: \_\_\_\_\_  
\_\_\_\_\_

**NOTES:**

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# RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

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**Part B. Section 2.** The EMPLOYER must provide this supplemental information to the health care professional (PLHCP) who will review the employee's medical questionnaire:

EMPLOYEE'S NAME: \_\_\_\_\_

EMPLOYEE'S JOB TITLE/CLASSIFICATION: \_\_\_\_\_

1. What type of respirator will this employee use?

Check the type(s) below (you can check more than one category):

\_\_\_\_\_ N-, R-, or P- filtering facepiece (disposable, "dust mask" type)

\_\_\_\_\_ Tight-fitting, air-purifying half-mask,

\_\_\_\_\_ Tight-fitting full-face mask

\_\_\_\_\_ Air-purifying type

\_\_\_\_\_ Supplied air type

\_\_\_\_\_ Powered-air purifying respirator (PAPR)

\_\_\_\_\_ Tight-fitting, full face mask

\_\_\_\_\_ Loose-fitting helmet or hood

\_\_\_\_\_ Self-Contained Breathing Apparatus (SCBA)

\_\_\_\_\_ Escape (gas mask)

2. What is the approximate weight of the respirator and any tanks or air hoses?

\_\_\_\_\_

3. Will the employee use any of the following items with these respirator(s)?

a. HEPA filters Yes / No

b. Canisters (gas masks) Yes / No

c. Cartridges (air-purifying) Yes / No

4. How often will the employee use the respirator(s)? (circle "yes" or "no" for all answers that apply)

a. Escape only (no rescue duties) Yes / No

b. Less than 2 hrs. per day Yes / No

c. Emergency rescue only Yes / No

d. 2 to 4 hrs. per day Yes / No

e. Less than 5 hrs. per week Yes / No

f. over 4 hrs. per day Yes / No

5. When the employee uses the respirator(s), is their 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. \_\_\_\_\_

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# RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

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*Examples of light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while 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, drilling, nailing performing assembly work, or transferring a moderate load (about 35 pounds) 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 pounds) on a level surface. (NOTE: A gallon of water weighs about 8 lbs; so, a full, 3-gallon, backpack sprayer weights about 25 lbs.)*

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 pounds) 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 pounds).*

6. Will the employee wear protective clothing and/or equipment (other than the respirator) when using their respirator? Yes / No

If "yes," describe this protective clothing and/or equipment: \_\_\_\_\_

\_\_\_\_\_

7. Will they be working in hot conditions (temperature more than 77 degrees F)? Yes / No

8. Will they be working in humid conditions? Yes / No

9. Describe the work they will be doing while using their respirator(s): \_\_\_\_\_

\_\_\_\_\_

10. Describe any special or hazardous conditions they might encounter when using a respiratory protection (for example, confined spaces, oxygen-deficient atmospheres, life threatening gases): \_\_\_\_\_

\_\_\_\_\_

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# RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

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11. Provide the following information, if you know it, for each toxic substance that they will be exposed to when using their 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: \_\_\_\_\_

Name of any other toxic substances that they will be exposed to while using a respirator:

\_\_\_\_\_

12. Describe any special responsibilities they will have while using their respirator(s) that may affect the safety and well-being of others (i.e., rescue, security): \_\_\_\_\_

\_\_\_\_\_

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