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): ________________________________________________
RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

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
5. Have you ever had any of the following cardiovascular or heart problems?
   a. Heart attack  
   b. Stroke  
   c. Angina  
   d. Heart failure  
   e. Swelling in your legs or feet (not caused by walking)  
   f. Heart arrhythmia (heart beating irregularly)  
   g. High blood pressure  
   h. Any other heart problems that you have been told about  

6. Have you ever had any of the following cardiovascular or heart symptoms?
   a. Frequent pain or tightness in your chest  
   b. Pain or tightness in your chest during physical activity  
   c. Pain or tightness in your chest that interferes with your job  
   d. In the past 2 years, have you noticed your heart skipping or missing a beat  
   e. Heartburn or indigestion that is not related to eating  
   f. Any other symptoms that you think may be related to heart or circulation problems  

7. Do you currently take medication for any of the following problems?
   a. Breathing or lung problems  
   b. Heart trouble  
   c. Blood pressure  
   d. Seizures (fits)  

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  
   b. Skin allergies or rashes  
   c. Anxiety  
   d. General weakness or fatigue  
   e. Any other problem that interferes with your use of a respirator  

9. Would you like to discuss your answers with the health care professional who will review this questionnaire? 

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?  

11. Do you currently have any of the following vision problems?
   a. Wear contact lenses  
   b. Wear glasses  
   c. Color blind  
   d. Any other eye or vision problem  

12. Have you ever had an injury to your ears, including a broken ear drum?  

13. Do you currently have any of the following hearing problems?
   a. Difficulty hearing
   b. Wear a hearing aid
   c. Any other hearing or ear problem

14. Have you ever had a back injury?

15. Do you currently have any of the following musculoskeletal problems?
   a. Weakness in any of your arms, hands, legs, or feet
   b. Back pain
   c. Difficulty fully moving your arms and legs
   d. Pain or stiffness when you lean forward or backward at the waist
   e. Difficulty fully moving your head up or down
   f. Difficulty fully moving your head side to side
   g. Difficulty bending at your knees
   h. Difficulty squatting to the ground
   i. Climbing a flight of stairs or a ladder carrying more than 25 pounds
   j. Any other muscle or skeletal problem that interferes with using a respirator

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?

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?

3. Have you ever worked with any of the materials, or under any of the conditions listed below:
   a. Asbestos
   b. Coal (for example, mining)
   c. Silica (e.g., sandblasting)
   d. Iron
   e. Tungsten/cobalt (grinding or welding this material)
   f. Tin
   g. Dusty environments
   h. Beryllium
RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

1. Any other hazardous exposures       Yes / No
2. 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:
RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

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. _____________
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 weighs 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): ________________

________________________________

________________________________
RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

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): ________________________________
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________