NATIONAL OCCUPATIONAL HEALTH SERVICES (NOHS)

6732 East 41st Street, Tulsa, OK 74145

Voice: 918.794.4777 Fax: 918.794.4778

OSHA MEDICAL EVALUATION QUESTIONNAIRE FOR RESPIRATOR USE
(SEE 29 CFR 1910.134 APPENDIX C)

General Information			Work Environment
Can you read? YES ☐ NO ☐	Today's Date:	Project Locations	Duration/Frequency of Respirator Use:
Your Name (Plese print clearly):	Age:	Sex : (Please check one) ☐M ☐F	Expected Physical Work Effort ☐ Light ☐ Moderate ☐ Heavy
Height: _______FT _______IN	Weight: _______LBS	Job Title or Craft	Protective Clothing to be Worn:
Telephone Number:		Best Time to Call:	Weather conditions you may be working in:
Social Security Number:		Employer/Company:	
Type of Respirator to be Used: **(CIRCLE ALL THAT APPLY)** Disposable ½ Face Full Face PAPR Airline SCBA Other:		**Types of Respirators Worn Previously:** **(CIRCLE ALL THAT APPLY)** Disposable ½ Face Full Face PAPR Airline SCBA Other:	Do you understand that you may contact the healthcare professional who will review this questionnaire during business hours at the number above? ☐ Yes ☐ No
This questionnaire must be used to determine whether an employee meets minimum physical requirements for wearing a respirator.		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 and send this questionnaire to the health care professional who will review it.	

Health History (Check yes or no for each question.)

Question	Yes	No
1. Do you currently smoke or have you smoked tobacco in the last month? Smoking Since: ___/___/___ Packs per day: ___	☐ Yes	☐ No
1a. Within the last month, have you had a common cold or the symptoms of a cold (sore throat, sinus congestion, fever)?	☐ 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. Gout	☐ Yes	☐ No
E. Claustrophobia (fear of closed-in places)	☐ Yes	☐ No
F. Trouble smelling odors	☐ Yes	☐ No
G. Broken nose or cheek bone	☐ 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 (Date ___/___/___)	☐ Yes	☐ No
F. Tuberculosis (Date ___/___/___)	☐ 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 have been told about	☐ Yes	☐ No

If yes, describe:

Question	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 up a slight incline	☐ Yes	☐ No
C. Shortness of breath when walking with other people at an ordinary pace	☐ 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 job	☐ Yes	☐ No
G. Coughing that produces phlegm	☐ 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

If yes, describe

5. **Have you ever had any of the following cardiovascular or heart problems?**		
A. Heart attack . . . . . .(If yes, Date ___/___/___)	☐ Yes	☐ No
B. Stroke . . . . (If yes, Date ___/___/___)	☐ Yes	☐ No
C. Angina	☐ Yes	☐ No
D. Heart failure . . . . . (If yes, Date ___/___/___)	☐ Yes	☐ No
E. Swelling in your legs or feet	☐ Yes	☐ No
F. Heart arrhythmia	☐ Yes	☐ No
G. High blood pressure	☐ Yes	☐ No
H. Any other heart problems	☐ Yes	☐ No

If yes, describe:

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. Do antacids relieve your heartburn or indigestion	☐ Yes	☐ No
G. Any other symptoms that you think may be related to heart or circulation	☐ Yes	☐ No

If yes, describe:

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
E. Diabetes	☐ Yes	☐ No

If yes, describe:

8. **If you have used a respirator, have you experienced any of the following problems?**		
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 problems that interfere with your use of a respirator	☐ Yes	☐ No

If yes, describe

9. **Have you ever lost vision in either eye? . .**	☐ Yes	☐ No

10. **Do you currently have any of the following vision problems?**		
A. Wear contact lenses	☐ Yes	☐ No
B. Wear prescription glasses	☐ Yes	☐ No
C. Need prescription glasses to do your job . . .	☐ Yes	☐ No
D. Color blindness	☐ Yes	☐ No
E. Any other eye or vision problems	☐ Yes	☐ No

If yes, describe:

11. **Have you ever had any injury to your ears, including a broken eardrum?**	☐ Yes	☐ No

12. **Do you currently have any of the following hearing problems?**		
A. Difficulty hearing	☐ Yes	☐ No
B. Consistently hearing ringing in your ears . .	☐ Yes	☐ No
C. Wear a hearing aid	☐ Yes	☐ No
D. Any other ear or hearing problems	☐ Yes	☐ No

If yes, describe:

13. **Have you ever had a back injury? . . . . . .**	☐ Yes	☐ No

14. **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 moving your arms or legs	☐ Yes	☐ No
D. Pain or stiffness when you lean forward or backward at the waist	☐ Yes	☐ No
E. Difficulty fully moving your head fully 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. Difficulty climbing a flight of stairs or ladder carrying more than 25 pounds	☐ Yes	☐ No
J. Any other muscle or skeletal problems	☐ Yes	☐ No

If yes, describe:

***** If you answered yes to any of the above questions, see if the consultation sections below apply to you. *****

A. **Only persons with <u>diabetes</u> answer these questions.**		
1. Do you take any oral medication for your diabetes	☐ Yes	☐ No
2. Do you take insulin shots for your diabetes . .	☐ Yes	☐ No
3. Are you following the instructions your physician has given you for care of your diabetes	☐ Yes	☐ No
4. Do you and your physician consider your diabetes under control	☐ Yes	☐ No
5. Have you had an episode of low blood sugar in the past three months	☐ Yes	☐ No
6. Do you carry some type of sugar with you at all times	☐ Yes	☐ No

If yes, describe:

B. **Only persons with <u>high blood pressure</u> answer these questions.**		
1. Has your physician prescribed blood pressure medicine	☐ Yes	☐ No
2. Do you take your blood pressure medication as ordered by your physician	☐ Yes	☐ No
3. Have you started a new blood pressure medication within the past two weeks	☐ Yes	☐ No
4. Do you get your blood pressure checked regularly	☐ Yes	☐ No

If yes, describe:

C. Only persons with asthma answer these questions.			**E. Only persons with seizures answer these questions.**		
1. Have you had an asthma attack within the past year	☐ Yes	☐ No	1. Do you have epilepsy	☐ Yes	☐ No
2. Do you take asthma medication daily	☐ Yes	☐ No	2. Was your seizure (fit) related to a fever or other medical condition, not epilepsy	☐ Yes	☐ No
3. Do you take asthma medication only when you have an attack	☐ Yes	☐ No	3. Have you had a seizure within the past year.	☐ Yes	☐ No
4. Have you worn a respirator since you have been diagnosed with asthma	☐ Yes	☐ No	4. Do you take medication for seizures (fits)	☐ Yes	☐ No
5. Did the respirator affect your asthma	☐ Yes	☐ No	5. If you take medication, are you taking it as your doctor ordered	☐ Yes	☐ No
6. Did the respirator make it more difficult to breath	☐ Yes	☐ No	6. If you have had a seizure within the past year, how many	_____	
D. Only persons with shortness of breath answer these questions.			**F. Only persons with heart attacks answer these questions.**		
1. Do you have shortness of breath only during high level physical activity	☐ Yes	☐ No	1. Was your heart attack treated by open heart surgery or angioplasty	☐ Yes	☐ No
2. Did you first notice your shortness of breath within the past year	☐ Yes	☐ No	2. Was your heart attack treated with medicines only	☐ Yes	☐ No
3. Do you consider your shortness of breath abnormal	☐ Yes	☐ No	3. Have you had any more symptoms or angina since treatment	☐ Yes	☐ No
4. When you are short of breath do you have dizziness, chest pain, or nausea	☐ Yes	☐ No	4. Have you seen your doctor for a check up since your heart attack	☐ Yes	☐ No
5. Have you worn a respirator since you experienced shortness of breath	☐ Yes	☐ No	5. Has your doctor restricted your work duties.		
6. Did the respirator make it more difficult to breathe	☐ Yes	☐ No			
If yes, describe:			**If yes, describe:**		

I certify that I answered all questions accurately and to the best of my knowledge.	
Employee Signature	Date

For Technician Use Only

Vital Signs:

Blood Pressure: _________________ Pulse: ________________ Temp: _________________ Resp: _________________

Eardrums: Left_________________ Right _________________ Facial Def: _________________

Testing Technician ID: ______________________________

Comments: _______________________________________

____

____

____

FVC = ___________________

FEVI = ____________________

FEV1/FVC = ___________________

Interpretation = Normal

Other = ____________________

Physician Signature: ____ Date:____