Occupational Medicine
201 Plageman Building **|** Corvallis, Oregon 97331-5801
Phone: 541-737-7566 **|** Confidential Fax: 541-737-7236

Confidential Respirator User Medical Questionnaire

Name: _____Date: _____

Employee ID #:_____OSU Department: _____

Work Phone: _____Email address:_____

Business mailing address: _____

Name of Supervisor: _____Email Address:_____
(**To notify when approval is received)**

Instructions:

1. Complete the attached "OSU OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE"
2. **Send all originals** to OSU Occupational Medicine.
3. A licensed health care provider in the Occupational Medicine will review the questionnaire and forward approval to use a respirator to EH&S. A physical exam may be required in response to this questionnaire.
4. Contact EH&S to set up an appointment for training and fit testing.

☐ **YES** ☐ **NO** Have you previously been seen by an Occupational Medicine clinic for a work-related medical clearance? If YES, Occupational Medicine will send a copy of a medical records disclosure to you at the business mailing address listed above.

I understand that if my health status changes or if significant changes occur in the workplace conditions that require respirator use (e.g., physical work effort, protective clothing, temperature), I will contact OSU Occupational Medicine to be re-evaluated.

_____ _____
Employee's Signature Date

CONFIDENTIAL RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

To the employer: Answers to questions in Section 1 and to question 9 in Section 2, 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. Seal this form in an envelope and mail it directly to the address above or send via Confidential Fax at (541) 737-7236. Call Occupational Medicine at (541) 737-7566 to reach the health care professional who will review this form if you have any questions.

Section 1 (OSHA Part A): The following information must be provided by every employee who has been selected to use any type of respirator. **Please print.**

- Are you an OSU student? ☐ **yes** ☐ **no**

1. Name: _____ Employee ID # _____
2. Today's date: _____ DOB _____
3. Age (to nearest year): _____
4. Gender (please circle): Male Female
5. Height: _____ ft. _____in.
6. Weight: _____ lbs.
7. 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? ☐ **yes** ☐ **no**
11. Check the type of respirator you will use (you can check more than one category):
    - ☐ N, R, or P disposable filtering facepiece respirator (filter mask, non-cartridge only)
    - ☐ Other type
        - ☐ Half-face type
        - ☐ Full-facepiece type
        - ☐ Powered air-purifying respirator (PAPR) with hood
        - ☐ Powered air-purifying respirator (PAPR) with facepiece
        - ☐ Supplied air
        - ☐ Self-contained breathing apparatus (SCBA)
12. Have you worn a respirator before? ☐ **yes** ☐ **no**
13. If "yes," what type(s)? (not brand name)_____

Section 2 (OSHA Part A): 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. ☐ **yes** ☐ **no** Do you ***currently*** smoke tobacco, or have you smoked tobacco in the last month?

2. Have you ***ever had*** any of the following conditions?
a. ☐ **yes** ☐ **no** Seizures
b. ☐ **yes** ☐ **no** Diabetes (sugar disease)
c. ☐ **yes** ☐ **no** Allergic reactions that interfere with your breathing
d. ☐ **yes** ☐ **no** Claustrophobia (fear of closed-in places)
e. ☐ **yes** ☐ **no** Trouble smelling odors

3. Have you ***ever had*** any of the following pulmonary or lung problems?
a. ☐ **yes** ☐ **no** Asbestosis
b. ☐ **yes** ☐ **no** Asthma
c. ☐ **yes** ☐ **no** Chronic bronchitis
d. ☐ **yes** ☐ **no** Emphysema
e. ☐ **yes** ☐ **no** Pneumonia
f. ☐ **yes** ☐ **no** Tuberculosis
g. ☐ **yes** ☐ **no** Silicosis
h. ☐ **yes** ☐ **no** Pneumothorax (collapsed lung)
i. ☐ **yes** ☐ **no** Lung cancer
j. ☐ **yes** ☐ **no** Broken ribs
k. ☐ **yes** ☐ **no** Any chest injuries or surgeries
l. ☐ **yes** ☐ **no** Any other lung problem that you've been told about

4. Do you ***currently*** have any of the following symptoms of pulmonary or lung illness?
a. ☐ **yes** ☐ **no** Shortness of breath
b. ☐ **yes** ☐ **no** Shortness of breath when walking fast on level ground or walking up a slight hill or incline
c. ☐ **yes** ☐ **no** Shortness of breath when walking with other people at an ordinary pace on level ground
d. ☐ **yes** ☐ **no** Have to stop for breath when walking at your own pace on level ground
e. ☐ **yes** ☐ **no** Shortness of breath when washing or dressing yourself
f. ☐ **yes** ☐ **no** Shortness of breath that interferes with your job
g. ☐ **yes** ☐ **no** Coughing that produces phlegm (thick sputum)
h. ☐ **yes** ☐ **no** Coughing that wakes you early in the morning
i. ☐ **yes** ☐ **no** Coughing that occurs mostly when you are lying down
j. ☐ **yes** ☐ **no** Coughing up blood in the last month
k. ☐ **yes** ☐ **no** Wheezing
l. ☐ **yes** ☐ **no** Wheezing that interferes with your job
m. ☐ **yes** ☐ **no** Chest pain when you breathe deeply
n. ☐ **yes** ☐ **no** Any other symptoms that you think may be related to lung problems

5. Have you ***ever had*** any of the following cardiovascular or heart problems?
a. ☐ **yes** ☐ **no** Heart attack
b. ☐ **yes** ☐ **no** Stroke
c. ☐ **yes** ☐ **no** Angina
d. ☐ **yes** ☐ **no** Heart failure
e. ☐ **yes** ☐ **no** Swelling in your legs or feet (not caused by walking)
f. ☐ **yes** ☐ **no** Heart arrhythmia (heart beating irregularly)
g. ☐ **yes** ☐ **no** High blood pressure
h. ☐ **yes** ☐ **no** Any other heart problem that you've been told about

6. Have you ***ever had*** any of the following cardiovascular or heart symptoms?
a. ☐ **yes** ☐ **no** Frequent pain or tightness in your chest
b. ☐ **yes** ☐ **no** Pain or tightness in your chest during physical activity
c. ☐ **yes** ☐ **no** Pain or tightness in your chest that interferes with your job
d. ☐ **yes** ☐ **no** In the past two years, have you noticed your heart skipping or missing a beat
e. ☐ **yes** ☐ **no** Heartburn or indigestion that is not related to eating
f. ☐ **yes** ☐ **no** 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. ☐ **yes** ☐ **no** Breathing or lung problems
b. ☐ **yes** ☐ **no** Heart trouble
c. ☐ **yes** ☐ **no** Blood pressure
d. ☐ **yes** ☐ **no** Seizures

8. If you've used a respirator, have you ***ever had*** any of the following problems?
(If you've **never used** a respirator, check here ☐ and go to question 9)
a. ☐ **yes** ☐ **no** Eye irritation
b. ☐ **yes** ☐ **no** Skin allergies or rashes
c. ☐ **yes** ☐ **no** Anxiety
d. ☐ **yes** ☐ **no** General weakness or fatigue
e. ☐ **yes** ☐ **no** Any other problem that interferes with your use of a respirator

***Note:* If you answered YES to any of questions 1 – 8 in Section 2, you must also complete Section 3.**

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* **self-contained breathing apparatus (SCBA)**. For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. ☐ **yes** ☐ **no** **Have you ever lost** vision in either eye (temporarily or permanently)

11. **Do you currently have** any of the following vision problems?
a. ☐ **yes** ☐ **no** Wear contact lenses:
b. ☐ **yes** ☐ **no** Wear glasses:
c. ☐ **yes** ☐ **no** Color blind:
d. ☐ **yes** ☐ **no** Any other eye or vision problem

12. ☐ **yes** ☐ **no** **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. ☐ **yes** ☐ **no** Difficulty hearing:
b. ☐ **yes** ☐ **no** Wear a hearing aid:
c. ☐ **yes** ☐ **no** Any other hearing or ear problem:

14. ☐ **yes** ☐ **no** **Have you ever had** a back injury?

15. **Do you currently have** any of the following musculoskeletal problems?
a. ☐ **yes** ☐ **no** Weakness in any of your arms, hands, legs, or feet:
b. ☐ **yes** ☐ **no** Back pain:
c. ☐ **yes** ☐ **no** Difficulty fully moving your arms and legs:
d. ☐ **yes** ☐ **no** Pain or stiffness when you lean forward or backward at the waist:
e. ☐ **yes** ☐ **no** Difficulty fully moving your head up or down:

f. ☐ **yes** ☐ **no** Difficulty fully moving your head side to side:
g. ☐ **yes** ☐ **no** Difficulty bending at your knees:
h. ☐ **yes** ☐ **no** Difficulty squatting to the ground:
i. ☐ **yes** ☐ **no** Climbing a flight of stairs or a ladder carrying more than 25 lbs:
j. ☐ **yes** ☐ **no** Any other muscle or skeletal problem that interferes with using a respirator:

Section 3 (OSHA Part B): **Complete this section if you answered YES to any part of questions 1 - 8 in section 2.** Consult your supervisor if necessary before answering the following questions:

1. **How often** are you expected to use the respirator(s)?
   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

2. **During the period you are using the respirator**, 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.).

3. **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:)

_____

4. **Will you be working** under temperature extremes during respirator use (check all that apply)
   ☐ <0ºF ☐ 0 to 32 º F ☐ 77 to 90 º F ☐ > 90 º F

5. **Will you be working** under dry (< 30% relative humidity) or humid (> 70% RH) conditions?
   ☐Yes ☐No (circle appropriate condition)

6. **Describe the work** you'll be doing while you're using your respirator(s):

_____

_____

7. **Describe any special or hazardous** conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

_____

_____