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**OSHA Respirator Medical Evaluation Questionnaire (Mandatory)**

If you have any questions, contact ThedaCare At Work - Appleton (920) 380-4999

**To the employee:** Can you read (check yes or no):  Yes  No

*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: \_\_\_\_\_ (month/day/year)      Company Name: \_\_\_\_\_
- 2. Your name: \_\_\_\_\_      Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
- 3. Your address: \_\_\_\_\_
- 4. Your age (to nearest year): \_\_\_\_\_      5. Sex:  Male /  Female      6. Your height: \_\_\_\_\_ ft \_\_\_\_\_ in
- 7. Your weight: \_\_\_\_\_ pounds      8. Your job title: \_\_\_\_\_
- 9. A phone number where you can be reached by the healthcare professional who reviews this questionnaire (include the Area Code): (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_      10. Best time to phone you at this number: \_\_\_\_\_
- 11. Has your employer told you how to contact the healthcare professional who will review this questionnaire (check yes or no):  Yes  No

12. Check the type of respirator you will use (you can check more than one category):

<input type="checkbox"/> <b>N</b> , <input type="checkbox"/> <b>R</b> , or <input type="checkbox"/> <b>P</b> Disposable Respirator (filter-mask, non-cartridge type only)
<input type="checkbox"/> Half- or full-face piece type, powered-air purifying, supplied-air
<input type="checkbox"/> Self-contained breathing apparatus (SCBA)

Have you worn a respirator?  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?

Seizures (fits)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Claustrophobia (fear of closed in places)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes (sugar disease)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Trouble smelling odors	<input type="checkbox"/> YES <input type="checkbox"/> NO
Allergic reactions that interfere with your breathing	<input type="checkbox"/> YES <input type="checkbox"/> NO		

**3. Have you ever had any of the following pulmonary or lung problems?**

Asbestosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Silicosis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pneumothorax (collapsed lung)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chronic Bronchitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Lung Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO
Emphysema	<input type="checkbox"/> YES <input type="checkbox"/> NO	Broken Ribs	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pneumonia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Any chest injuries or surgeries	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tuberculosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Any other lung problem that you've been told about	<input type="checkbox"/> YES <input type="checkbox"/> NO

**4. Do you currently have any of the following symptoms of pulmonary or lung illness?**

Shortness of Breath	<input type="checkbox"/> YES <input type="checkbox"/> NO
Shortness of breath when walking fast on level ground or walking up a slight hill or incline	<input type="checkbox"/> YES <input type="checkbox"/> NO
Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/> YES <input type="checkbox"/> NO
Shortness of breath when washing or dressing yourself	<input type="checkbox"/> YES <input type="checkbox"/> NO
Shortness of breath that interferes with your job	<input type="checkbox"/> YES <input type="checkbox"/> NO
Coughing that produces phlegm (thick sputum)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Coughing that wakes you early in the morning:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Coughing that occurs mostly when you are lying down:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Coughing up blood in the last month:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Wheezing	<input type="checkbox"/> YES <input type="checkbox"/> NO
Wheezing that interferes with your job:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chest pain when you breathe deeply:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Any other symptoms that you think may be related to lung problems:	<input type="checkbox"/> YES <input type="checkbox"/> NO

**5. Have you ever had any of the following cardiovascular or heart problems?**

Heart attack	<input type="checkbox"/> YES <input type="checkbox"/> NO	Swelling in your legs or feet (not caused by walking)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart arrhythmia (heart beating irregularly)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Angina	<input type="checkbox"/> YES <input type="checkbox"/> NO	High blood pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart Failure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Any other heart problem that you have been told about	<input type="checkbox"/> YES <input type="checkbox"/> NO

**6. Have you ever had any of the following cardiovascular or heart symptoms?**

Frequent pain or tightness in your chest	<input type="checkbox"/> YES <input type="checkbox"/> NO	In the past two years have you noticed your heart skipping or missing a beat	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pain or tightness in your chest during physical activity	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heartburn or indigestion that is not related to eating	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pain or tightness in your chest that interferes with your job	<input type="checkbox"/> YES <input type="checkbox"/> NO	Any other symptoms that you think may be related to heart or circulation problems	<input type="checkbox"/> YES <input type="checkbox"/> NO

**7. Do you currently take medication for any of the following problems?**

Breathing or Lung Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart Trouble	<input type="checkbox"/> YES <input type="checkbox"/> NO	Seizures (fits)	<input type="checkbox"/> YES <input type="checkbox"/> NO

**8. If you've used a respirator, have you ever had any of the following problems?**

**(If you've never used a respirator, go to question 9)**

Eye Irritation	<input type="checkbox"/> YES <input type="checkbox"/> NO	General weakness or fatigue	<input type="checkbox"/> YES <input type="checkbox"/> NO
Skin Allergies or Rashes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Any other problem that interferes with your use of a respirator	<input type="checkbox"/> YES <input type="checkbox"/> NO
Anxiety	<input type="checkbox"/> YES <input type="checkbox"/> 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