OSHA Respirator Use Medical Questionnaire

Mankato

Location: ☐ Mankato ☐ Fairmont
☐ New Prague ☐ Springfield
☐ St. James ☐ Waseca

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, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it. If you have any questions regarding this questionnaire or the reviewal process, please contact Mayo Clinic Health System to speak to the designated personnel who oversees the respirator medical evaluations, in the Occupational/Employee Health Services department.

PART A. SECTION 1. Every employee who has been selected to use any type of respirator must provide the following information. **All questions are mandatory**. (Please print)

Can you read (Check one): ☐ Yes ☐ No | Name

Date | Job Title | Company

Age | Date of Birth | Sex: ☐ Male ☐ Female | Phone number where you can be reached | Best time to call

Home Address | City | State | Zip

RESPIRATOR USE INFORMATION
Type (Check ALL types used or to be used)
☐ Disposable dust mask (N, R or P)
☐ Air purifying respirator (Cartridge)
☐ Positive pressure air–line
☐ Powered air purifying
☐ Self–contained breathing apparatus (SCBA)
☐ HazMat protective clothing
☐ Other (List):
Weight of respirator:
Weight of other protective equipment:

LEVEL OF WORK EFFORT WITH PROTECTIVE EQUIPMENT (Check one)
☐ Light (typing, light assembly, etc.)
☐ Medium (Pushing wheelbarrow, nailing)
☐ Heavy (Lifting over 50 lbs, shoveling)
☐ Strenuous (Emergency rescue)

POTENTIAL EXPOSURE (Check ALL that apply)
☐ Nuisance dust
☐ Solvents/petroleum/paints
☐ Acids/bases
☐ IDLH immediate hazards
☐ Metal dust/fumes
☐ Biological agents (TB, etc.)
☐ Hot humid conditions
☐ Asbestos
☐ Other (List):

EXTENT OF USE (Check one)
☐ Daily _________ hours per day
☐ Once per week or more
☐ Once per month or more
☐ Less than once per month
☐ Emergency use only

Have you worn a respirator (Check one): ☐ Yes ☐ No | Date last used | If Yes, what type(s)

PART A. SECTION 2. Every employee who has been selected to use any type of respirator must provide the following information. **All questions are mandatory.** (Please print)

	Yes	No
1. 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. Seizures (Fits)?		
B. Diabetes (Sugar disease)?		
C. Allergic reactions that interfere with your breathing?		
D. Claustrophobia (Fear of closed in places)?		
E. Trouble smelling odors?		

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	Yes	No
3. Have you **ever had** any of the following pulmonary or lung problems?		
A. Asbestosis?		
B. Asthma?		
C. Chronic bronchitis?		
D. Emphysema?		
E. Pneumonia?		
F. Tuberculosis?		
G. Silicosis?		
H. Pneumothorax (Collapsed lung)?		
I. Lung cancer?		
J. Broken ribs?		
K. Any chest injuries or surgeries?		
L. Any other lung problem that you have been told about?		
4. Do you **currently** have any of the following symptoms or pulmonary or lung illness?		
A. Shortness of breath?		
B. Shortness of breath when walking fast on level ground or walking up a slight hill or incline?		
C. Shortness of breath when walking with other people at an ordinary pace on level ground?		
D. Have to stop for breath when walking at your own pace on level ground?		
E. Shortness of breath when washing or dressing yourself?		
F. Shortness of breath that interferes with your job?		
G. Coughing that produces phlegm (Thick sputum)?		
H. Coughing that wakes you early in the morning?		
I. Coughing that occurs mostly when you are lying down?		
J. Coughing up blood in the last month?		
K. Wheezing?		
L. Wheezing that interferes with your job?		
M. Chest pain when you breathe deeply?		
N. 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. 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 problem 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?		
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 two years, have you noticed your heart skipping or missing a beat?		
E. Heartbrun or indigestion that 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, check Yes and go to questions 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 talk to the health care professional who will review this questionnaire about your answers to this questionnaire?		
Questions 10. through 15. below must be answered by every employee who has been selected to use either a full–facepiece respirator or a self–contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.		
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 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?		

	Yes	No
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. Difficulty 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?		
Please comment here if Yes was answered to any questions:		
PART B **MEDICAL HISTORY** Voluntary: Response to questions 16–25 is voluntary for users of all types of respirators.		
16. Have you been exposed to any accidents/spills/exposures since your last exam?		
17. Have you had any job changes or new exposures since your last exam?		
18. Do you have physical symptoms or medical problems that you believe are related to your job? If Yes:		
A. Do symptoms occur in any pattern at work, such as time, place or processes?		
B. Are symptoms affected by time off such as vacations or weekends?		
C. Are symptoms affected by the use of personal protective equipment?		
D. Have symptoms been medically evaluated?		
19. Do you have a sore or burning nose or throat at work?		
20. Do you have trouble concentrating or remembering?		
21. Have any of your coworkers experienced health problems connected to this job?		
22. Can you smell any chemicals while using your respirator?		
23. Have you had teeth extracted within the past year?		
24. Have you gained or lost weight in the last year?		
25. Have you experienced any of the following within the **past five years**?		
A. Any other eye vision problem?		
B. Have you **ever had** an injury to your ears, including a broken ear drum?		
C. Do you **currently** have any of the following hearing problems?		
D. Difficulty hearing?		
E. Wear a hearing aid?		
F. Any other hearing or ear problem?		
G. Have you **ever had** a back injury?		
H. Do you		

WORK HISTORY: (List your jobs, starting with the most recent. Include military service)

Company	Job Title(s)	Number of Months/Years

Have you ever worked, or do you work with: ☐ Foundry ☐ Sandblasting ☐ Mine ☐ Quarry ☐ Textile Mill ☐ Asbestos ☐ Dust ☐ Fumes, Chemicals ☐ Other

If Yes, when?	How long?

Do you have a second job or side business? If Yes, what?

Date of your last physical exam	Height	Present weight

EMPLOYMENT STATEMENT
CERTIFYING ACCURACY OF INFORMATION

I certify that my answers to the questions on this history form are true and accurate. I am aware that this information will be used by medical provider in making a determination of my ability to wear a respirator while performing my current job.

Signature	Date
Medical Reviewer	Date