Yale Health Center
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New Haven, CT. 06520
(203) 432-0071

DEPARTMENT OF EMPLOYEE HEALTH
OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

For Employee Health Use Only			
	N95/100		Full Face Neg Press
	PAPR		SCBA
	½ Face Neg Press		Airline Resp

TO THE EMPLOYER:
Answers to questions in Section1, and to question 9 in Section 2 of Part A, do not require a medical examination.

TO THE EMPLOYEE: Can you read *(circle one)*: 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: _____
2. Your name: _____
3. Your age *(to nearest year)*: _____
4. Sex *(circle one)* Male Female
5. Your height: _____ ft. _____ in.
6. Your weight: _____ lbs.
7. Your job title: _____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire *(including 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 *(circle one)*:
    Yes No
11. Check the type of respirator you will use *(you can check more than one category)*:
    _____ N, R or P disposable respirator (filter-mask, non-cartridge type only).
    _____ Other type (for example, half-or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator *(circle one)* Yes No
    - If "yes"" what type(s): _____

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 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) Asthma: ..... Yes No
   c) Chronic bronchitis: ..... Yes No
   d) Emphysema: ..... Yes No
   e) Pneumonia: ..... Yes No
   f) Tuberculosis: ..... 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've 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 breathe deeply:..... Yes No
   n) Any other symptoms 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: ..... Yes No
   b) Stroke: ..... Yes No
   c) Angina: ..... Yes No
   d) Heart Failure: ..... Yes No
   e) Swelling in your legs or feet (not caused by walking): ..... Yes No
   f) Heart arrhythmia (heart beating irregularly): ..... Yes No
   g) High blood pressure: ..... Yes No
   h) Any other heart problem that you've 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: ..... 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) Any other symptoms that you think may be related to heart or circulation problems: ..... Yes No

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 (fits): ..... Yes No

8. If you used a respirator, have you ever had any of the following problems? If you never used a respirator, check the following space and go to question 9. _____
   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 problem that interferes with your use of a respirator: ..... Yes No

9. Would you like to talk to the health care professional who will review this questionnaire about your answer to the questionnaire: ..... Yes No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA).

10. Have you ever lost vision in either eye (temporarily or permanently): ..... Yes No
11. Do you currently have any of the following vision problems?
    a) Wear contact lenses: ..... Yes No
    b) Wear glasses: ..... Yes No
    c) Color blind: ..... Yes No
    d) Any other eye or vision problem: ..... Yes No
12. Have you ever had an injury to your ears, including a broken ear drum: ..... Yes No
13. Do you currently have any of the following hearing problems?
    a) Difficulty hearing: ..... Yes No
    b) Wear a hearing aid: ..... Yes No
    c) Any other hearing or ear problem: ..... Yes No
14. Have you ever had a back injury: ..... Yes No
15. 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 fully moving your arms and legs: ..... Yes No
    d) Pain or stiffness when you lean forward or backward at the waist: ..... Yes No
    e) Difficulty fully moving your head 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) Climbing a flight of stairs or a ladder carrying more than 25 lbs: ..... Yes No
    j) Any other muscle or skeletal problem that interferes with using a respirator: ..... Yes No

PART B

1. 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: ..... Yes No
   - If "yes", name the chemicals if you know them: _____
   _____
   _____
   _____
2. Have you ever worked with any of the materials, or under any of the conditions, listed below:
   a) Asbestos: ..... Yes No
   b) Silica (e.g., in sandblasting): ..... Yes No
   c) Tungsten/cobalt (e.g., grinding or welding this material): ..... Yes No
   d) Beryllium: ..... Yes No
   e) Aluminum: ..... Yes No
   f) Coal (for example, mining): ..... Yes No
   g) Iron: ..... Yes No
   h) Tin: ..... Yes No
   i) Dusty environments: ..... Yes No
   j) Any other hazardous exposures: ..... Yes No
   - If "yes" describe the exposures: _____
   _____
   _____
3. List any second jobs or side business you have: _____
   _____
4. List your previous occupations: _____
   _____
5. List your current and previous hobbies: _____
   _____
6. Have you been in the military services?..... Yes No

- If "yes," were you exposed to biological or chemical agents (either in training or combat): ..... Yes No

7. Have you ever worked on a HAZMAT team? ..... Yes No
8. 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: _____
9. Will you be using any of the following items with your respirator(s)?
   a) HEPA Filters: ..... Yes No
   b) Canisters (for example, gas masks): ..... Yes No
   c) Cartridges: ..... Yes No
10. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you?:
   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
11. During the period you are using the respirator(s), is your work effort *(check one)*:
   Light _____ Moderate _____ Heavy _____
12. When you're using your respirator will you be wearing protective clothing and/or equipment (other than the respirator): Yes No
   - If "yes" describe this protective clothing and/or equipment: _____
13. Will you be working under hot conditions (temperature exceeding 77degrees): ..... Yes No
14. Will you be working under humid conditions: ..... Yes No
15. Describe the work you'll be doing while you're using your respirator(s): _____
16. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases): _____

Signature _____ Date: _____

Date of Birth: _____ Net I.D. _____

EMPLOYER'S INFORMATION

Type of respirator: _____

Weight of respirator: _____

Expected Physical work effort when respirator is in use: _____

Additional protective equipment to be worn: _____

Please note any extreme of temperature or humidity: _____

PLEASE RETURN COMPLETED FORM TO:

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55 Lock Street
PO Box 20837
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FAX: 432-7828