SAFE.FITTESTING.2.1 Medical Questionnaire

OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

To the employee:

You are to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain confidentiality, your manager must not look at or review your answers. Your manager will provide you with an envelope and confidential seal to deliver or send this questionnaire to the Medical Director for review. **Refer to procedure SAFE.FITTESTING.1.0 for submittal instructions.**

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination. Follow-up examinations must be provided for employees who give positive answers to any of the questions numbered 1 through 8 in Part A, Section 2.

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: _____ Employee Number: _____
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 Medical Director reviewing the questionnaire (include the Area Code): _____
9. The best time to reach you at this number: _____
10. Has your Manager told you how to contact the Medical Director who will review this questionnaire (circle one): Yes/No
11. Check the type of respirator you will use (you can check more than one):
    a. _____ Respirator N-95
    b. _____ Respirator N-99
    c. _____ Respirator N-100
12. Have you ever worn a respirator before (circle one): Yes/No

    If "yes", what type(s): _____

Medical Questionnaire

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 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: Yes/No
    b. Diabetes (sugar disease): Yes/No
    c. Allergic reactions that interfere with 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 (TB): 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 that 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 (chest pain): 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: Yes/No
8. If you've used a respirator, have you *ever had* any of the following problems?
   (If you've never used a respirator, check the following space _____ and go to question 9:)
    a. Eye irritation (burning, itching, swelling): 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 Medical Director who will review this questionnaire about your answers to this questionnaire? Yes/No

Submit completed questionnaire in sealed envelope to Department Manager. Sealed questionnaires will be forwarded to the Medical Director for evaluation.