OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (MANDATORY)

(To Be Completed By the Employee)

Note 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. Can the employee read? If the employee requires assistance with this questionnaire, please complete the following:
Employee Assisted By: Phone #: _____

Note to the employee: Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is a 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. Mandato Em lo ees selected to use any type of respirater must rovide the followin information

1)Toda 'sdate:	2 Your name:
3)Your age (to nearest ear :	4) Sex (check one : D Male D Female
5 Your hei ht: ft. in.	6) Your wei ht: lbs. 7) Your job title:
8) A phone number where you can be reached by the health care professional who reviews this uestionnaire (include the Area Code):	( ) _____
9) The best time to phone you at this number:	10) Your Social Security Number:
11) Has your employer told you how to contact the health care professional who will review this questionnaire?	D YES O NO

NOTE: The below information is available from your plant manager or supervisor

12) Check the type of respirator you will use (you can check more than one):	O N, R, or P disposable respirator (filter-mask, non-cartridge type only) O Other type (for example, half or full facepiece type, powered-air purifying). Specify:_____ O Self-contair _____ pparatus and supplied air respirator
13 Have ou worn a res irator? D YES O NO	If "yes," what type (s): _____

Part A. Section 2 (Mandatory) Questions 1 through 10 below must be answered by every employee who has been selected to use any type ofrespirator (please check "yes" or "no")

1.	Have you ever used a respirator?	O YES O NO
	a. Has respirator use caused any of the following:	D YES O NO
	b. Eye irritation when using a respirator?	O YES O NO
	c. Skin allergies or rashes when using a respirator?	O YES O NO
	d. Anxiety, choking or hyperventilation (over-breathing) while using a respirator?	O YES O NO
	e. General weakness or fatigue when using a respirator?	O YES O NO
	f. Any other problem that interferes with your use of a respirator?	O YES O NO
2.	Do you currently smoke tobacco, or have you ever smoked?	O YES O NO
	a. Do you currently smoke tobacco, or have you ever smoked?	D YES O NO
	b. Do you still smoke?	O YES O NO
	c. Number of years smoked:	O Y ES O NO
	d. Number of packs of cigarettes smoked per day:	O YES O NO
	Have you ever had any of the following conditions?	
3.	Seizures?	D YES O NO
	a. Within the last two (2) years?	D YES O NO
	b. Are you currently under the care of MD for your seizures?	D YES O NO
	c. Are your seizures under control?	O YES O NO
4.	Diabetes (sugar disease)?	O YES O NO
	a. Are you currently under the care of MD for diabetes?	O YES O NO
	b. Is your diabetes under control?	D YES O NO
	c. How do you control your diabetes?	D YES O NO
5.	Allergic reactions that interfere with your breathing?	D YES O NO
6.	Claustrophobia (fear of closed-in places)?	O YES O NO
	a. Does wearing a respirator cause your claustrophobia?	O YES O NO

7. Trouble smelling odors? D YES O NO
8. Unexplained loss of consciousness? D YES O NO
   a. Within the last two (2) years? D YES O NO

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

9. Asbestosis? D YES O NO
10. Asthma? D YES O NO
    a. Treated within the last two (2) years? D YES O NO
    b. Are you currently taking any Asthma medication? D YES O NO

IL Chronic bronchitis? D YES O NO

12. Emphysema? D YES O NO
13. Pneumonia? D YES O NO
14. Are you currently receiving treatment for pneumonia? D YES O NO
    a. Has it been resolved? D YES O NO
15. Tuberculosis? D YES O NO
    a. Have you received treatment? D YES O NO
    b. Has it been resolved? D YES O NO
16. Silicosis? D YES O NO
17. Pneumothorax (collapsed lung)? D YES O NO
    a. Have you received treatment? D YES O NO
    b. Has it been resolved? D YES O NO
18. Lung cancer? Broken ribs? D YES O NO
19. Have you received treatment? D YES O NO
20. Has it been resolved? D YES O NO
21. Any chest injuries or surgeries D YES O NO
    a. Have you received treatment? D YES O NO
    b. Has it been resolved? D YES O NO
22. Any other lung problems that you are aware of? D YES O NO

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

23. Shortness of breath? D YES O NO
24. Shortness of breath when walking fast on level ground or walking up a slight hill or incline? D YES O NO
25. Shortness of breath when walking with other people at an ordinary pace on level ground? D YES O NO
26. Have to stop for breath when walking at your own pace on level ground? D YES O NO
27. Shortness of breath when washing or dressing yourself? D YES O NO
28. Shortness of breath that interferes with your job? D YES O NO
29. Persistent cough (most days for three or more months per year)? D YES O NO
30. Coughing that produces phlegm (thick sputum)? D YES O NO
31. Persistent phlegm (most days for three or more months per year)? D YES O NO
32. Coughing that wakes you early in the morning? D YES O NO
33. Coughing that occurs mostly when you are lying down? D YES O NO
34. Coughing up blood in the last month? D YES O NO
35. Wheezing? D YES O NO
36. Wheezing that interferes with your job? D YES O NO
37. Chest pain when you breathe deeply? Any other symptoms that you think may be related to lung problems? D YES O NO

    (describe): ——————————————————————

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

38. Heart attack? D YES O NO
    a. What was the date of your heart attack?_____
39. Stroke? D YES O NO
    a. If yes, has your MD medically cleared you to perform a job requiring a respirator? D YES O NO
40. Angina (chest pain)? D YES O NO
41. Heart failure? D YES O NO
42. Swelling in your legs or feet (not caused by walking}? D YES O NO
43. Heart arrhythmia (heart beating irregularly or very fast)? D YES O NO
44. High blood pressure? D YES O NO
    a. Are you under the care of MD for high blood pressure? D YES O NO
    b. Is your blood pressure under control with medication? D YES O NO
45. Any other heart problems that you are aware of? D YES O NO

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

46. Frequent pain or tightness in your chest? O YES O NO
    a. Within the last two years? D YES O NO
47. Pain or tightness in your chest during physical activity? O YES O NO
    a. Within the last two years? O YES O NO
48. Pain or tightness in your chest that interferes with your job? D YES O NO
    a. Within the last two years? D YES O NO
49. In the past two years, have you noticed your heart skipping or missing a beat? D YES O NO
    a. Have you seen a MD for this condition? O YES O NO
    b. Has your MD medically cleared you to perform a job requiring a respirator? D YES O NO
50. Heartburn or indigestion that is not related to eating? D YES O NO
    a. Within the last two years? O YES O NO
51. Any other symptoms that you think may be related to heart or circulation problems (describe):

_____

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

52. Breathing or lung problems? O YES O NO
53. Heart trouble? O YES O NO
54. Blood pressure? D YES O NO
55. Seizures (fits)? D YES O NO
56. Diabetes (shot or pill)? D YES O NO

Miscellaneous

57. Have you seen a doctor in the last year for a medical problem? D YES O NO
58. Have you ever lost vision in either eye? D YES O NO
    a. Was it permanent? D YES O NO
59. Do you currently have any of the following vision problems? D YES O NO
    a. Wear contact lenses? O YES O NO
    b. Wear glasses? D YES O NO
    c. Are you required to wear glasses while wearing a respirator? D YES O NO
    d. Color blind? O YES O NO
60. Any other eye or vision problem? D YES O NO
61. Have you ever had an injury to your ears, including a broken ear drum? D YES O NO
    a. Is your ear drum still currently ruptured? D YES O NO
62. Do you currently have any of the following hearing problems? D YES O NO
63. Difficulty hearing? O YES O NO
64. Wear a hearing aid? D YES O NO
65. Any other hearing or ear problem? D YES O NO
66. Have you ever had a back injury? O YES O NO
    a. Does this currently make use of a respirator difficult? D YES O NO

Do you currently have any of the following musculoskeletal problems?

67. Weakness in any of your arms, hands, legs, or feet? D YES O NO
    a. Does this currently make use of a respirator difficult? D YES O NO
68. Back pain? D YES O NO
    a. Does this currently make use of a respirator difficult? D YES O NO
69. Difficulty fully moving your arms and legs? O YES O NO
    a. Does this currently make use of a respirator difficult? D YES O NO
70. Pain or stiffness when you lean forward or backward at the waist? D YES O NO
    a. Does this currently make use of a respirator difficult? D YES O NO
71. Difficulty fully moving your head up or down? D YES O NO
    a. Does this currently make use of a respirator difficult? D YES O NO
72. Difficulty fully moving your head side to side? D YES O NO
    a. Does this currently make use of a respirator difficult? D YES O NO
73. Difficulty bending at your knees? D YES O NO
    a. Does this currently make use of a respirator difficult? D YES O NO
74. Difficulty squatting to the ground? D YES O NO
    a. Does this currently make use of a respirator difficult? D YES O NO
75. Climbing a flight of stairs or a ladder carrying more than 25 pounds? D YES O NO
    a. Does this currently make use of a respirator difficult? D YES O NO

76. Any other muscle or skeletal problem that interferes with using a respirator? O YES O NO

a. Does this currently make use of a respirator difficult? O YES O NO

Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

The above answers have been supplied by me and are true to the best of my knowledge.

_____ _____

Employee Signature Date