AULTWORKS
OCCUPATIONAL MEDICINE

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (MANDATORY) – PART A

(App. C Section 5144 and App. C 1910.134)

To the Employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, does not require a medical examination.

To the Employee: **Can you read? (circle one) YES / NO** **Your Company**:_____

Manager: _____

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.

Expected physical effort:

[ ] Light Effort (Sitting/standing while writing, performing light assembly work: or controlling machines)
[ ] Moderate Effort: (Sitting/standing/walking using tools, performing assembly work, lifting/ pushing moderate loads)
[ ] Heavy Effort (Lifting heavy loads (>35lbs.); shoveling, walking up an 8º grade, climbing stair with a load)

PLEASE PRINT

PART A. SECTION 1. (MANDATORY) The following information must be provided by employees who use any type of respirator.

Name:	Age (nearest year):	Sex: M / F	Today's Date:
Address:			
SSN:	DOB:	Height: ____ft., _____in.	Weight:_____lbs.
Your job title:		Home phone:	Work Phone:
Has your employer told you how to contact the health care professional who will review this questionnaire: YES / NO			
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).			
Have you worn a respirator: ❒ Yes ❒ No	If yes, what types:		

PART A. SECTION 2. Questions 1 thru 9 below must be answered by employees who use any type of respirator.

	PLEASE CHECK "YES" or "NO"	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:		
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		

	PLEASE CHECK "YES" or "NO"	YES	NO
	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've been told about		
4.	Do you *currently* have any of the following symptoms of 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 (no caused by walking)		
	f. Heart arrhythmia (heart beating irregularly)		
	g. High blood pressure		
	h. Any other heart problem that you've been told about:		
6.	Have you *ever had* any of the following cardiovascular 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. Heartburn or indigestion 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		
8.	If you've used a respirator, have you *ever had* any of the following problems? (If never used a respirator, check the following space and go to questions 9.)		
	a. Eye irritation		
	b. Skin allergies or rashes		

PLEASE CHECK "YES" or "NO"		YES	NO
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?		

Employee Signature: Date:

****STOP HERE! CONTINUE ONLY IF YOU USE A FULL-FACE OR SCBA RESPIRATOR****

PLEASE CHECK "YES" or "NO"		YES	NO
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 blindness		
d.	Any other eye or 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		
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 that 25 lbs.		
j.	Any other muscle or skeletal problem that interferes with using a respirator		

Employee Signature: Date:

Reviewer's comments on history:

_____ _____ Review Date:_____

M.D. / D.O. / P.A. / R.N. / COHN Provider Printed Name