



Kaiser On-the-Job®

www.kaisersantarosa.org/ohs

707 566-5550

Last Name: _____ First _____ MI _____

Kaiser Medical Record Number: _____

Employer: _____ Department: _____

Job Title/Classification: _____

OSHA Respirator Medical Evaluation Questionnaire

To the employee: Can you read? 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. The following information must be provided by every employee who has been selected to use any type of respirator (please print clearly).

1. Today's date: _____ Last four digits of Social Security # _____
2. Maiden or former name: _____
3. Your age (to nearest year): _____ Date of Birth: _____
4. Sex (select one): Male Female
5. Phone number(s) where you can be reached and you give permission for a health care professional who reviews this questionnaire to leave message(s) containing medical information:
 - a. M-F, 9-5 (_____) _____ - _____
 - b. (_____) _____ - _____
6. Your complete address: _____

-
7. Check the type of respirator you will use (you can check more than one category):
 - a. N, R, or P disposable respirator (filter-mask, non-cartridge type only).
 - b. Other type (for example, Half-or-Full face piece, powered-air purifying, supplied-air)
 - c. Self-contained breathing apparatus (SCBA).

8. Have you worn a respirator previously? Yes No ?
If yes, what type(s)? Choose from list above. _____

9. Please list chemicals/dust that respirator is to protect against: _____

10. Your height: _____ ft. _____ in.
11. Your weight: _____ lbs.
12. Has your employer told you how to contact the health care professional who will review this questionnaire? (707) 566-5550, Kaiser Yes No ?

Directions for Part A. Section 2. and Part B. of OSHA Respiratory Questionnaire

The following is an OSHA regulated history regarding your use, or potential use, of respiratory protection equipment. Please read all the questions carefully.

■ Explain any "Yes" answers next to the question (otherwise you may need an appointment to provide an explanation).

■ Explain whether this is a current problem or is it resolved?

■ Are you taking medications, undergoing testing, does it prevent you from using protective respiratory equipment? Or using (SCBA)?

Feel free to attach another sheet if needed. Please note that a follow-up phone call, physical examination, or further testing, may be required based upon your answers.

Part A. Section 2. Every employee who has been selected to use any type of respirator must answer these questions.

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? (Explain, give details, dates)

- | | |
|---|---|
| a. Seizures (fits)? | Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> |
| b. Diabetes (Sugar disease)? Name of Medications? | Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> |
| c. Allergic reactions that interfere with your breathing? | Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> |
| d. Claustrophobia (fear of closed-in places)? | Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> |
| e. Trouble smelling odors? | Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> |
| f. High cholesterol? Name of Medications? | Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> |

3. Have you ever had any of the following pulmonary or lung problems? (Explain "Yes" and Give Dates)

- | | |
|--|---|
| a. Asbestosis? | Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> |
| b. Asthma? | Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> |
| c. Chronic bronchitis? | Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> |
| d. Emphysema? | Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> |
| e. Pneumonia? | Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> |
| f. Tuberculosis? | Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> |
| g. Silicosis? | Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> |
| h. Pneumothorax (collapsed lung)? | Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> |
| i. Lung cancer? | Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> |
| j. Broken ribs? | Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> |
| k. Any chest injuries or surgeries? | Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> |
| l. Any other lung problem that you've been told about? | Yes <input type="checkbox"/> No <input type="checkbox"/> ? <input type="checkbox"/> |

Diagnosis: _____ **Date:** _____

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness? (**Explain” Yes”**)
- 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 our 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? (**Explain “Yes” Give dates.**)
- 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 beats irregularly)? Yes No ?
 - g. High blood pressure? **Medications?** _____ Yes No ?
 - h. Any other heart problems that you've been told about? Yes No ?

Explain: _____

- i. Family history of heart disease? Yes No ?
- Who?** _____ **Diagnosis?** _____ **Age at diagnosis?** _____

6. **Have you ever** had any of the following cardiovascular or heart symptoms? (**Explain “Yes” and Give Dates**)
- 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 ?
 - e. **Name of Medications for above problem(s):**
 - 1. _____
 - 2. _____
 - 3. _____

8. If you've **never** used a respirator, skip to question 9 and check this box: **No Respirator**

If you've used a respirator, have you ever had any of the following problems? **Please Describe.**

- 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. How often are you expected to use a respirator (respirators)?

- 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 ?

10. Work requiring respirator use is (mark all that apply) **Light** **Moderate** **Heavy**

*Examples of **light** work are: sitting while writing, performing light assembly work, and controlling machines.*
*Examples of **moderate** work are: standing while nailing, transferring a moderate load (about 35 lbs.) at trunk level, and walking on a level surface about 2 mph.*
*Examples of **heavy** work are: lifting a heavy load (about 50 lbs) from the floor to your waist, shoveling, and standing while bricklaying.*

11. Do you normally have a beard, goatee, mustache, or other facial hair growth? Yes No ?

12. How much exercise (outside of work) do you get in a typical week? Write “**NONE**” or describe.

What activity do you do? : _____
#day/wk _____ #minutes/day _____

13. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? Yes No ?

PART B.:

****YOU CAN SKIP TO SIGNATURE SECTION IF YOU DO NOT WEAR FULL-FACE RESPIRATOR OR SCBA****

Questions 15 to 20 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). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

15. **Have you ever** lost vision in either eye:

- Temporarily? Yes No ?
- Permanently? Yes No ?

16. Do you **currently** have any of the following vision problems?

- a. Wear contact lenses? Yes No ?
- b. Wearing glasses? Yes No ?
- c. Color blind? Yes No ?
- d. Any other eye or vision problem? Yes No ?

17. **Have you ever** had an injury to your ears, including a broken eardrum? Yes No ?

18. Do you **currently** have any of the following hearing problems?

a. Difficulty hearing? Yes No ?

b. Wearing a hearing aid? Yes No ?

c. Any other hearing or ear problem? Yes No ?

19. **Have you ever** had a back injury? Date: _____ Treatment: _____
_____ Yes No ?

20. Do you **currently** have any of the following musculoskeletal problems? (**Explain "Yes"**)

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 moving your head side to side? Yes No ?

g. Difficulty bending at your knees? Yes No ?

h. Difficulty squatting to the ground? Yes No ?

j. Difficulty 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 ?

Signature: _____ **Date:** _____

Reviewed by: _____ **Date:** _____