Employee Health and Wellness
The Central Maine Medical Family

Hood: Facial Hair or Failed Test ☐

OSHA Respirator Medical Evaluation Questionnaire

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.

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. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator.

1. Today's date:
2. Your name:
3. Date of birth:
4. Your sex: ○ Male ○ Female
5. Your height: ft. in.
6. Your weight: lbs. Weight loss or gain > 10lbs. in past year? ○ Yes ○ No
7. Your job title:
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the 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:
◉ 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-facepiece-type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator: ○ Yes ○ No

    If "yes," what type(s):

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 (answer by checking the box if the answer is YES.

1. I currently smoke tobacco, or have you smoked tobacco in the last month: ☐

2. I have had the following medical 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. I haver had the following pulmonary or lung problems:
   a. Asbestosis: ☐
   b. Asthma: ☐
   c. Chronic bronchitis: ☐
   d. Emphysema: ☐
   e. Pneumonia: ☐
   f. Tuberculosis: ☐
   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. I currently have 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/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. I haver had the following cardiovascular or heart problems:
   a. Heart attack: ☐
   b. Stroke: ☐
   c. Angina: ☐
   d. Heart failure: ☐
   e. Swelling in your legs or feet (not 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. I have had the following cardiovascular or heart 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. I currently take medication for the following issues:
    a. Breathing or lung problems: ☐
    b. Heart trouble: ☐
    c. Blood pressure: ☐
    d. Seizures (fits): ☐

8. I have used a respirator and had the following issues:
    a. Eye irritation: ☐
    b. Skin allergies or rashes: ☐
    c. Anxiety: ☐
    d. General weakness or fatigue: ☐
    e. Any other issue that interferes with your use of a respirator: ☐

9. I would like to talk to the health care professional who will review this questionnaire about my answers to this questionnaire? ☐

Part A. Section 3: <u>Mandatory</u> - Questions about previous work or hobbies

1. List any second jobs or side businesses you have:

2. List your previous occupations:

3. List your current and previous hobbies:

4. Have you been in the military services:

5. Have you ever worked on a HAZMAT team:

6. 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):

    If "yes," name the medications if you know them:

All “Yes” answers (other than to questions in Section 1, and to question 9 in Section 2 of Part A,) have been reviewed by an RN.

Employee Signature: /s/

Date:

EHS staff Reviewer Signature: /s/

Date: