Marshfield Clinic®

HEALTH SYSTEM

Marshfield Medical Center

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

This questionnaire is used in determining whether or not you have a medical condition that may affect your ability to safely wear a respirator. We anticipate being able to approve most people for respirator uses based on this questionnaire alone. In some cases we may ask for more information or additional medical testing/evaluation. Fit testing is also required and is done separately. Statements and answers on this form need to be complete. All medical information is considered confidential. To maintain your confidentiality, the information provided on this form will be reviewed by Employee Health (EH) to determine your ability to safely wear a respirator and will not be shared with your supervisor.

ALL INFORMATION MUST BE COMPLETED FOR RESPIRATOR APPROVAL Today's Date ____/____/____

Name:	Date of Birth:	Sex: ☐ Male ☐ Female
Facility:		Job Title:
Phone # where we can contact you: __________		Best time to be reached at this #: __________
Check type of respirator you will use (check all that apply): ☐ N-, R-, or P- series disposable respirator (filter mask, non-cartridge) ☐ Other Type (specify) __________		Have you ever been Fit tested before: ☐ Yes ☐ No
I am aware I contact EH if I have any questions about this questionnaire or this process: _______ (initials)		

1. Do you currently smoke tobacco, or have you smoked tobacco in the the last month? ☐ No ☐ Yes __________

2. Have you ever had any of the following conditions?

- Seizures ☐ No ☐ Yes __________
- Diabetes (sugar disease) ☐ No ☐ Yes __________
- Allergic reactions that interfere with your breathing ☐ No ☐ Yes __________
- Claustrophobia (fear of closed-in spaces) ☐ No ☐ Yes __________
- Trouble smelling odors ☐ No ☐ Yes __________

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

- Asbestosis ☐ No ☐ Yes __________
- Asthma ☐ No ☐ Yes __________
- Chronic bronchitis ☐ No ☐ Yes __________
- Emphysema ☐ No ☐ Yes __________
- Pneumonia ☐ No ☐ Yes __________
- Tuberculosis ☐ No ☐ Yes __________
- Silicosis ☐ No ☐ Yes __________
- Pneumothorax (collapsed lung) ☐ No ☐ Yes __________
- Lung cancer ☐ No ☐ Yes __________
- Broken ribs ☐ No ☐ Yes __________
- Any chest injuries or surgeries ☐ No ☐ Yes __________
- Any other lung problem that you've been told about ☐ No ☐ Yes __________

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

- Shortness of breath ☐ No ☐ Yes __________
- Shortness of breath when walking fast on level ground or walking up a slight hill or incline ☐ No ☐ Yes __________
- Shortness of breath when walking with other people at an ordinary pace on level ground ☐ No ☐ Yes __________
- Have to stop for breath when walking at your own pace on level ground ☐ No ☐ Yes __________
- Shortness of breath when washing or dressing yourself ☐ No ☐ Yes __________
- Shortness of breath that interferes with your job ☐ No ☐ Yes __________
- Coughing that produces phlegm (thick sputum) ☐ No ☐ Yes __________
- Coughing that wakes you early in the morning ☐ No ☐ Yes __________
- Coughing that occurs mostly when you are lying down ☐ No ☐ Yes __________
- Coughing up blood in the last month ☐ No ☐ Yes __________

- Wheezing that interferes with your job ☐ No ☐ Yes ____________
- Chest pain when you breathe deeply ☐ No ☐ Yes ____________
- Any other symptoms that you think may be related to lung problems ☐ No ☐ Yes ____________

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

- Heart attack ☐ **No** ☐ **Yes** ____________
- Stroke ☐ No ☐ Yes ____________
- Angina ☐ No ☐ Yes ____________
- Heart failure ☐ No ☐ Yes ____________
- Swelling in your legs or feet (not caused by walking) ☐ No ☐ Yes ____________
- Heart arrhythmia (heart beating irregularly) ☐ No ☐ Yes ____________
- High blood pressure ☐ No ☐ Yes ____________
- Any other heart problem that you've been told about ☐ No ☐ Yes ____________

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

- Frequent pain or tightness in your chest ☐ No ☐ Yes ____________
- Pain or tightness in your chest during physical activity ☐ No ☐ Yes ____________
- Pain or tightness in your chest that interferes with your job ☐ No ☐ Yes ____________
- In the past two years, have you noticed your heart skipping or missing a beat ☐ No ☐ Yes ____________
- Heartburn or indigestion that is not related to eating ☐ No ☐ Yes ____________
- Any other symptoms that you think may be related to heart or circulation problems ☐ No ☐ Yes ____________

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

- Breathing or lung problems ☐ **No** ☐ **Yes** ____________
- Heart trouble ☐ No ☐ Yes ____________
- Blood pressure ☐ No ☐ Yes ____________
- Seizures (fits) ☐ No ☐ Yes ____________

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 the following question)** ☐

- Eye irritation ☐ No ☐ Yes ____________
- Skin allergies or rashes ☐ No ☐ Yes ____________
- Anxiety ☐ No ☐ Yes ____________
- General weakness or fatigue ☐ No ☐ Yes ____________
- Any other problem that interferes with your use of a respirator ☐ No ☐ Yes ____________

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

Questions 10 to 15 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), this does not include PAPR use. For Employee who have been selected to use other types of respirators, answering these questions is voluntary.

10. **Have you ever lost vision in either eye (temporarily or permanently)?** ☐ No ☐ Yes ____________

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

- Wear contact lenses ☐ No ☐ Yes ____________
- Wear glasses ☐ No ☐ Yes ____________
- Color blind ☐ No ☐ Yes ____________
- Any other eye or vision problem ☐ No ☐ Yes ____________

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

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

- Difficulty hearing ☐ No ☐ Yes ____________
- Wear a hearing aid ☐ No ☐ Yes ____________
- Any other hearing or ear problem ☐ No ☐ Yes ____________

14. **Have you ever had a back injury?** ☐ No ☐ Yes ____________

15. Do you currently have any of the following musculoskeletal problems?

- Weakness in any of your arms, hands, legs, or feet ☐ No ☐ Yes ____________
- Back pain ☐ No ☐ Yes ____________
- Difficulty fully moving your arms and legs ☐ No ☐ Yes ____________
- Pain or stiffness when you lean forward or backward at the waist ☐ No ☐ Yes ____________
- Difficulty fully moving your head up or down ☐ No ☐ Yes ____________
- Difficulty fully moving your head side to side ☐ No ☐ Yes ____________
- Difficulty bending at your knees ☐ No ☐ Yes ____________
- Difficulty squatting to the ground ☐ No ☐ Yes ____________
- Climbing a flight of stairs or a ladder carrying more than 25 lbs ☐ No ☐ Yes ____________
- Any other muscle or skeletal problem that interferes with using a respirator ☐ No ☐ Yes ____________

16. Have you ever worked with any of the materials, or under any of the conditions, listed below:

- Asbestos ☐ No ☐ Yes ____________
- Silica (e.g., in sandblasting) ☐ No ☐ Yes ____________
- Tungsten/cobalt (e.g., grinding or welding this material) ☐ No ☐ Yes ____________
- Beryllium ☐ No ☐ Yes ____________
- Aluminum ☐ No ☐ Yes ____________
- Coal (for example, mining) ☐ No ☐ Yes ____________
- Iron ☐ No ☐ Yes ____________
- Tin ☐ No ☐ Yes ____________
- Dusty environments ☐ No ☐ Yes ____________
- Any other hazardous exposures ☐ No ☐ Yes ____________

17. List any second jobs or side businesses you have: ____________________________

____

18. Describe the work you'll be doing while you are using your respirator(s):

____

____

____

______________________________ ______________________

Employee Signature Date

OFFICE USE ONLY

Bp: __________ Pulse: __________ Resp: __________ Ht: __________ Wt: __________

☐ See Annual Form ☐ See Post-Office form for today's vitals

	Normal	Abnormal	Comments
Heart Tones			
Breath Sounds			
Facial Features			
Other			

☐ Instructions for use reviewed, successful fit test of N95

Remarks/Restriction: ____

____

____

____

____

____

☐ Approved ☐ Approved with Restrictions ☐ Denied ☐ More information Needed (specify)

______________________________ ______________________

Signature of Evaluating Health Care Provider Date