ASPIRUS™
Passion for excellence.
Compassion for people.

BUSINESS HEALTH
3000 Westhill Drive, Suite 100, Wausau, WI 54401
P 844.888.5873 | businesshealth@aspirus.org

Respirator Questionnaire
Appendix C to 1910.134: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 (circle one): 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 (please print).

1. Today's date:____

2. Your name:____

3. Your Date of Birth (DOB): ______________________________________

4. Your age (to nearest year):_____________________________________

5. Your Employer: ____

6. Sex (circle one): Male Female

7. Your height:__________ft.__________in.

8. Your weight:____________lbs.

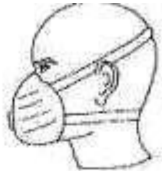
9. Your job title:____

10. A phone number where you can be reached by the health care professional who reviews thisquestionnaire (include the Area Code): ______________________________

11. The best time to phone you at this number: ______________________

12. Has your employer told you how to contact the health care professional who will review thisquestionnaire (circle one): .... Yes No

13. Check the type of respirator you will use (you can check more than one category):



_X_ N R or P disposable ____ Half Faced ____ Full Faced ____ Atmosphere Supplying (SCBA or Airline) ESCAPE ONLY

14. Have you worn a respirator (circle one): ....Yes No

If "yes," what type(s):______________________________

____ N R or P disposable ____ Half Faced ____ Full Faced ____ Atmosphere Supplying (SCBA or Airline) ESCAPE ONLY

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 (please circle "yes" or "no").

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month: .... Yes No
   If yes, how much do you smoke daily____________________(packs per day).
   How many years have you smoked_________________(years).

PLHCP:____

2. Have you ***ever*** had any of the following conditions?
   a. Seizures (fits): .... Yes No
   If YES:
   i. Was the most recent seizure with-in the past two years?
   _____Yes _____No
   ii. Are you currently taking any prescription medication for seizures?
   _____Yes _____No
   iii. Are you currently under a doctor's care for seizures?
   _____Yes _____No
   b. Diabetes (sugar disease): .... Yes No
   Do you have Diabetes currently?
   _____Yes _____No
   If YES:
   i. How often do you check your sugar levels?
   ______Daily _____Weekly _____Less frequently
   ii. Have you ever had any episodes of hypoglycemia (low blood sugar) in the past six months?
   _____Yes _____No
   iii. Do you take insulin?
   _____Yes _____No
   iv. Do you take oral medications (pills) for diabetes?
   _____Yes _____No
   v. Do you and your doctor think that your blood sugar is under control?
   _____Yes _____No
   c. Allergic reactions that interfere with your breathing: .... Yes No
   d. Claustrophobia (fear of closed-in places): .... Yes No
   e. Trouble smelling odors (except when you had a cold): .... Yes No

PLHCP:____

3. Have you ***ever*** had any of the following pulmonary or lung problems?
   a. Asbestosis: .... Yes No
   b. Asthma: .... Yes No
   c. Chronic bronchitis: .... Yes No
   d. Emphysema: .... Yes No
   e. Pneumonia: .... Yes No
   f. Tuberculosis: .... Yes No
   g. Silicosis: .... Yes No
   h. Pneumothorax (collapsed lung): .... Yes No
   i. Lung cancer: .... Yes No
   j. Broken ribs: .... Yes No
   k. Any chest injuries or surgeries: .... Yes No
   l. Any other lung problem that you've been told about: .... Yes No

PLHCP:____

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

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 your 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

PLHCP:____

____

____

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

a. Heart attack: .... Yes No

b. Stroke: .... Yes No

c. Angina: .... Yes No

d. Heart failure: .... Yes No

i. Have you ever been diagnosed with Congestive Heart Failure (CHF)?
_____Yes _____No

e. Swelling in your legs or feet (not caused by walking): .... Yes No

f. Heart arrhythmia (heart beating irregularly): .... Yes No

g. High blood pressure: .... Yes No

h. Any other heart problem that you've been told about: .... Yes No

PLHCP:____

____

____

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

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

PLHCP:____

____

____

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

PLHCP:____

____

____

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 question 9.

a. Eye irritation: .... Yes No

b. Skin allergies or rashes: .... Yes No

c. Anxiety that occurs only when you use the respirator: .... Yes No

d. Unusual weakness or fatigue: .... Yes No

e. Any other problem that interferes with your use of a respirator: .... Yes No

PLHCP:____

____

____

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

PLHCP:____

____

____

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). For employees 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): ....…………….…...... Yes No
PLHCP:____
____

11. Do you currently have any of the following vision problems?
a. Wear contact lenses: ....………………………………………..... Yes No
b. Wear glasses: ....…………………………………………........... Yes No
c. Color blind: ....………………………………………....... Yes No
d. Any other eye or vision problem: ....…………………………….................. Yes No
PLHCP:____
____

12. Have you ever had an injury to your ears, including a broken ear drum: .....…………….............. Yes No
PLHCP:____
____

13. Do you currently have any of the following hearing problems?
a. Difficulty hearing: ....………………………………………..... Yes No
b. Wear a hearing aid: ....……………………………………….... Yes No
c. Any other hearing or ear problem: ....………………………………........... Yes No
PLHCP:____
____

14. Have you ever had a back injury: ....………………………………........ Yes No
i. Do you feel your back pain will interfere with you wearing a respirator?
_____Yes _____No
PLHCP:____
____

15. Do you currently have any of the following musculoskeletal problems?
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 fully moving your head side to side: ....…………………………..... Yes No
g. Difficulty bending at your knees: ....……………………………….... Yes No
h. Difficulty squatting to the ground: ....…………………………….…..... Yes No
i. 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

If you answered Yes to ANY of the above questions listed above explain how long ago or any medication taking for it.
____
____

Does any condition you answered Yes to above prevent you from wearing a SCBA………………. Yes No
PLHCP:____

Part B The following questions are mandatory for persons on HAZMAT teams or on Confined Space Rescue teams. The questions are optional for all others. You may be asked to complete them by the healthcare provider as deemed necessary.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: .... Yes No

   If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: ....Yes........................No

PLHCP:____

____

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: .... Yes No

   If "yes," name the chemicals if you know them:____

   ____

PLHCP:____

____

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

   a. Asbestos: .... Yes No
   b. Silica (e.g., in sandblasting): .... Yes No
   c. Tungsten/cobalt (e.g., grinding or welding this material): .... Yes No
   d. Beryllium: .... Yes No
   e. Aluminum: .... Yes No
   f. Coal (for example, mining): .... Yes No
   g. Iron: .... Yes No
   h. Tin: .... Yes No
   i. Dusty environments: .... Yes No
   j. Any other hazardous exposures: .... Yes No

   If "yes," describe these exposures:____

   ____

PLHCP:____

____

4. List any second jobs or side businesses you have:____

____

5. List your previous occupations:____

____

6. List your current and previous hobbies:____

____

7. Have you been in the military services? .... Yes No

   If "yes," were you exposed to biological or chemical agents (either in training or combat): .... Yes No

PLHCP:____

8. Have you ever worked on a HAZMAT team? .... Yes No
PLHCP:____
____

9. 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): .... Yes No
If "yes," name the medications if you know them:____________________________________
PLHCP:____
____

10. Will you be using any of the following items with your respirator(s)?
   a. HEPA Filters: .... Yes No
   b. Canisters (for example, gas masks): .... Yes No
   c. Cartridges: .... Yes No

PLHCP:____
____

11. How often are you expected to use the respirator(s)?
circle "yes" or "no" for all answers that apply to you
   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

PLHCP:____
____

12. During the period you are using the respirator(s), is your work effort:
   a. Light (less than 200 kcal per hour): .... Yes No
      If "yes," how long does this period last during the average shift:_________hrs._______mins.
      Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.

   b. Moderate (200 to 350 kcal per hour): .... Yes No
      If "yes," how long does this period last during the average shift:_________hrs._______mins.
      Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

   c. Heavy (above 350 kcal per hour): .... Yes No
      If "yes," how long does this period last during the average shift:_________hrs._______mins.
      Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and or equipment (other than the respirator) when you're using your respirator: .... Yes No

If "yes," describe this protective clothing and or equipment:______________________________

____

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): .... Yes No

15. Will you be working under humid conditions: .... Yes No

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

____

____

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases): ____________________________________

____

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance:____

Estimated maximum exposure level per shift:__________________________________

Duration of exposure per shift____

Name of the second toxic substance:____

Estimated maximum exposure level per shift:__________________________________

Duration of exposure per shift:____

Name of the third toxic substance:____

Estimated maximum exposure level per shift:__________________________________

Duration of exposure per shift:____

The name of any other toxic substances that you'll be exposed to while using your respirator:

____

____

____

19.Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security): ____________________________________

____

Employee signature:____Date:____________________

PLHCP signature:____Date:____________________

080814 – (jmw)