TOTAL URGENT CARE
Occupational Medicine
314 Highway 3162
Cut Off, LA 70433
Phone: (985) 632-1820 Fax: (985) 632-1824

OSHA RESPIRATORY MEDICAL EVALUATION QUESTIONNAIRE

NAME: _____DATE: _____

SSN: _____ DOB: _____ AGE: _____ SEX: _____

HEIGHT: _____ft _____in WEIGHT: _____lbs.

COMPANY: _____ JOB TITLE: _____

To the employee: Can you read (circle one): YES NO

Completion of this form is mandatory according to OSHA 1910.134 for any employee/ potential employee, who will be required to wear a respirator as part of his/her job. This questionnaire is part of the medical evaluation, which must be completed prior to fit testing and initial use of a respirator. It is very important that all questions are answered truthfully and completely. Answer each question requiring a yes or no answer by marking an **X** on the appropriate line. 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/potential employee who has been selected to use any type of respirator in their job.

A phone number where you can be reached by the health care professional who will review this questionnaire_____.
The best time to phone you at this number _____.

YES	NO	
☐	☐	Has your employer/potential employer told you how to reach the health care professional who will review this form?
☐	☐	Does this position require you to use a respirator? If yes, please identify the type(s) below: a. _____ N, R, or P disposable respirator (filter mask, non-cartridge type only) b. _____ Other type (for example, half-face piece or full-face piece type, powered-air purifying, supplied-air, or self- contained breathing apparatus)

YES	NO	
☐	☐	Have you ever worn a respirator? If Yes, what type(s)? _____

PART A- SECTION 2

The following questions must be answered by any employee/potential employee who will be using any type of respirator.

YES	NO	
☐	☐	1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? If YES, explain_____ _____

NAME: _____DOB: _____ DATE: _____

YES **NO** 2. Have you ever had any of the following condition?

☐ ☐ Seizures (fits or convulsions)
☐ ☐ Diabetes (sugar disease)
☐ ☐ Allergic reactions that interfere with your breathing
☐ ☐ Claustrophobia (fear of closed-in spaces)
☐ ☐ Trouble smelling odors
If YES, explain _____
_____

YES **NO** 3. Have you ever had any of the following pulmonary or lung problems?

☐ ☐ Asbestosis
☐ ☐ Asthma
☐ ☐ Chronic bronchitis
☐ ☐ Emphysema
☐ ☐ Pneumonia
☐ ☐ Tuberculosis
☐ ☐ Silicosis
☐ ☐ Pneumothorax (collapsed lung)
☐ ☐ Lung Cancer
☐ ☐ Broken Ribs
☐ ☐ Any chest injuries or surgeries
☐ ☐ Any other lung problems that you've been told about
If YES, explain _____
_____

YES **NO** 4. Do you **currently** have any of the following symptoms of pulmonary or lung illness*?*

☐ ☐ Shortness of breath
☐ ☐ Shortness of breath when walking fast on level ground or walking up a slight hill or incline
☐ ☐ Shortness of breath when walking with other people at an ordinary pace on level ground
☐ ☐ Have to stop for breath when walking at your own pace on level ground
☐ ☐ Shortness of breath when washing or dressing yourself
☐ ☐ Shortness of breath that interferes with your job
☐ ☐ Coughing that produces phlegm (thick sputum)
☐ ☐ Coughing that wakes you early in the morning
☐ ☐ Coughing that occurs mostly when you are lying down
☐ ☐ Coughing up blood in the last month
☐ ☐ Wheezing

NAME: _____DOB: _____ DATE: _____

YES **NO** 4. Do you **currently** have any of the following symptoms of pulmonary or lung illness continued?

☐ ☐ Wheezing that interferes with your job

☐ ☐ Chest pain when you breathe deeply

☐ ☐ Any other symptoms that you think may be related to lung problems
If YES, explain _____
_____
_____

YES **NO** 5. Have you **ever had** any of the following cardiovascular or heart problems?

☐ ☐ Heart attack

☐ ☐ Stroke

☐ ☐ Angina (chest pain related to the heart)

☐ ☐ Heart failure

☐ ☐ **S**welling in your legs or feet (not caused by walking)

☐ ☐ Heart arrhythmia (heart beating irregularly)

☐ ☐ High blood pressure

☐ ☐ Any other heart problem that you've been told about
If YES, Explain _____
_____

YES **NO** 6. Have you **ever had** any of the following cardiovascular or heart symptoms?

☐ ☐ Frequent pain or tightness in your chest

☐ ☐ Pain or tightness in your chest during physical activity

☐ ☐ Pain or tightness in your chest that interferes with your job

☐ ☐ In the past two years, have you noticed your heart skipping or missing a beat

☐ ☐ Heartburn or indigestion that is not related to eating

☐ ☐ Any other symptoms that you think may be related to heart or circulation problems
If YES, explain _____
_____

YES **NO** 7. Do you **currently** take medication for any of the following problems?

☐ ☐ Breathing or lung problems

☐ ☐ Heart trouble

☐ ☐ Blood pressure

☐ ☐ Seizures (fits)
If YES, explain _____
_____

NAME: _____DOB: _____ DATE: _____

YES **NO** 8. If you have used a respirator, have you ever had any of the following problems?
☐ (If you have never used a respirator mark NO and proceed to question 9)

☐ ☐ Eye irritation
☐ ☐ Skin allergies or rashes
☐ ☐ Anxiety
☐ ☐ General weakness or fatigue
☐ ☐ Any other problems that interferes with your use of a respirator
If YES, explain _____
_____

YES **NO** 9. Would you like to talk to the health care professional who will review your answers to this
☐ ☐ questionnaire?

Questions 10 to 15 must be answered by every employee/potential employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). If you are uncertain as to the type of respirator that you will be using, complete this section

YES **NO** 10. Have you **ever** lost vision in either eye (temporarily or permanently)?
☐ ☐ If YES, explain _____
_____

YES **NO** 11. Do you **currently** have any of the following vision problems?
☐ ☐ Wear contact lenses
☐ ☐ Wear glasses
☐ ☐ Color blind
☐ ☐ Any other eye or vision problem
If YES, explain _____
_____

YES **NO** 12. Have you **ever** had an injury to your ears including a broken ear drum?
☐ ☐ If YES, explain _____
_____

YES **NO** 13. Do you **currently** have any of the following hearing problems?
☐ ☐ Difficulty hearing
☐ ☐ Wear a hearing aid
☐ ☐ Any other hearing or ear problem
If YES, explain _____
_____

NAME: _____DOB: _____ DATE: _____

YES **NO** 14. Have you **ever** had a back injury?

☐ ☐ If YES, explain _____
_____

YES **NO** 15. Do you **currently** have any of the following musculoskeletal problems?

☐ ☐ Back pain
☐ ☐ Difficulty fully moving your arms and legs
☐ ☐ Pain or stiffness when you lean forward or back ward at the waist
☐ ☐ Difficulty fully moving your head up or down
☐ ☐ Difficulty moving your head side to side
☐ ☐ Difficulty bending at your knees
☐ ☐ Difficulty squatting to the ground
☐ ☐ Climbing a flight of stairs or a ladder carrying more than 25 pounds
☐ ☐ Any other muscle or skeletal problem that interferes with using a respirator
If YES, explain _____
_____

PART B

Any of the following questions, and other questions not listed may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire. Answer each question by marking an X on the appropriate line.

YES **NO** 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?

☐ ☐ If your answer was yes to the previous question, do you have feeling of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions?

☐ ☐ 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?
If yes, name the chemicals, if you know them: _____
_____

YES **NO** 3. Have you ever worked with any of the materials, or under any of the conditions listed below?

☐ ☐ Asbestos
☐ ☐ Silica (e.g. in sandblasting)
☐ ☐ Tungsten/cobalt (e.g.grinding or welding this material)
☐ ☐ Beryllium

NAME: _____DOB: _____ DATE: _____

YES **NO** 3. Have you ever worked with any of the materials, or under any of the conditions listed below continued?

☐ ☐ Aluminum

☐ ☐ Coal (e.g., mining)

☐ ☐ Iron

☐ ☐ Tin

☐ ☐ Dusty environments

☐ ☐ Any other hazardous exposures
If yes, describe_____
_____
_____

4. List any second jobs or side business that you may have: _____
_____

5. List your previous occupations: _____
_____

6. List your current and previous hobbies: _____
_____

YES **NO**

☐ ☐ 7. Have you ever been in the military services?
If yes to the previous question, were you exposed to biological or chemical agents (either in training or combat?) If yes, explain _____
_____

YES **NO**

☐ ☐ 8. Have you ever worked on a HAZMAT team?

☐ ☐ 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 other reason (including over-the-counter medications)? If yes, explain _____
_____

YES **NO** 10. Will you be using any of the following items with your respirator(s)?

☐ ☐ HEPA filters

☐ ☐ Canisters (for example, gas masks)

☐ ☐ Cartridges

NAME: _____DOB: _____ DATE: _____

YES **NO** 11. How often are you expected to use the respirator(s)?

☐ ☐ Escape only (no rescue)

☐ ☐ Emergency rescue only

☐ ☐ Less than 5 hours per week

☐ ☐ Less than 2 hours per day

☐ ☐ 2 to 4 hours per day

☐ ☐ Over 4 hours per day

YES **NO** 12. During the period you are using the respirator(s) is your work effort:

☐ ☐ **LIGHT** (less than 200kcal per hour)
[examples of light work effort are sitting while writing, drafting,
or performing light assembly work, or standing while operating a drill press1-2 lbs., or
controlling machines]? If yes, how long does this period last during the average shift?
_____ hrs _____min

☐ ☐ **MODERATE** (200-350 kcal per hour)
[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 (35 lbs.) at trunk level, walking on a level surface about 2mph, or pushing a wheelbarrow with a heavy load (100lbs.) on a level surface]
If yes, how long does this period last during the average shift? _____ hrs _____min

☐ ☐ **HEAVY** (above 350 kcal per hour)
[Examples of heavy work are lifting a heavy load (50lbs) from floor to your waist or shoulder, working on a loading dock, shoveling, climbing stairs with a heavy load]
If yes, how long does this period last during the average shift? _____ hrs _____min

YES **NO**

☐ ☐ 13. Will you be wearing protective clothing and/or equipment when you are using your respirator?

☐ ☐ 14. Will you be working under hot conditions (exceeding 77 degrees F)?

☐ ☐ 15. Will you be working under humid conditions?

16. Describe the work you will be doing while using your respirator: _____
_____
_____

17. Describe any special or hazardous conditions you might encounter while you are using your respirator: [Example confined spaces or life threatening gases] _____
_____
_____

NAME: _____DOB: _____ DATE: _____

18. Provide the following information, if you know it, for each toxic substance that you will be exposed to when you are 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: _____

The name of any other toxic substances that you will have while using your respirator(s)_____

_____

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

_____
_____
_____
_____
_____

COMMENTS FROM THE HEALTH CARE PROVIDER REVIEWING THIS QUESTIONNAIRE:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

Licensed Healthcare Provider **Date**

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RESPIRATORY PROTECTION EVALUATION

NAME: _____ DATE: _____

SSN: _____ DOB: _____ EMPLOYER: _____

The above named individual has completed the medical evaluation required by OSHA in the respiratory standard 1910.134. The evaluation consisted of the following checked items:

_____ OSHA questionnaire (1910.134)
_____ Medical examination
_____ Pulmonary function testing
_____ Chest x-ray
_____ Electrocardiogram
_____ Other _____

Based on the above evaluation:

_____ I find this individual medically qualified to use a respirator.

_____ I find this individual medically qualified to wear a respirator with the following limitation:
_____
_____
_____

_____ I DO NOT find this individual medically qualified to wear a respirator

_____ I recommend follow-up medical evaluations on a yearly basis.

_____ _____
Licensed Healthcare Provider Signature **Date**

I have been informed of the findings of my medical evaluation and authorized the release of the findings to the company.

_____ _____
Employee Signature **Date**