UMassMemorial

Employee Health Services
210 Lincoln Street, Lower Level
Worcester, MA 01605
Phone: 509-793-6400
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Respirator Medical Evaluation Questionnaire (Print Clearly)

Date: ____/____/____

Last Name: _____ First Name: _____ Employee or SS #: _____

DOB: ____/____/____ Home Phone: _____ Department: _____ Work Ext: _____

Employee Type (circle one):

Hosp Clinical Med School Resident Animal Medicine DOC Volunteer Other_____

Mandatory OSHA Respirator Medical Evaluation Questionnaire (Appendix C Sec. 1910.34)

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).

Your age: (to the nearest year): _____ Job Title: _____

Gender: Male Female Height: _____ ft. _____in. Weight: _____lbs.

Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes / No

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

a. ____ Disposable respirator (filter-mask, non-cartridge type only). For example: N95 mask.
b. ____ Other type (for example, half or full-face piece cartridge type, powered-air purifying [PAPR], supplied-air, self-contained breathing apparatus)

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

If "yes", what type(s):

_____

Questions 1 through 15 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 many packs/day currently or recently? _____ How many years have you smoked? _____

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

a. Seizures (fits): Yes / No If yes: When was your last seizure? _____ Are you taking seizure medicine? Yes / No
b. Diabetes (sugar disease): Yes / No If yes: Do you require insulin? Yes / No Have you had low sugar events? Yes / No
c. Allergic reactions that interfere with breathing: Yes / No If yes, describe:
_____
d. Claustrophobia (fear of closed-in places); Yes / No If yes, would wearing a respirator cause this symptom? Yes / No
e. Trouble smelling odors: Yes / No

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

a. Asbestos: Yes / No b. Asthma: Yes / No
c. Chronic bronchitis (lasting 3+ months): Yes / No d. Emphysema: Yes / No
e. Pneumonia: Yes / No If yes, recovered: Yes / No f. Tuberculosis: Yes / No
g. Silicosis: Yes / No
h. Pneumothorax (collapsed lung): Yes / No If yes, when: _____
i. Lung cancer: Yes / No j. Broken ribs: Yes / No If yes, when: _____
k. Any chest injuries or surgeries: Yes / No
l. Any other lung problem that you have been told about: Yes / No
If yes (k), please describe: _____

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

a. Shortness of breath: Yes / No
b. Shortness of breath when waking 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 in the early 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

If you answered "yes" to any of these questions, please answer the following:
Have you been evaluated by a doctor for these symptoms? Yes / No
Have you had a breathing test (spirometry or pulmonary function test)? Yes / No If yes, when: _____
Have you had a chest x-ray or other imaging test of your lungs? Yes / No If yes, was it normal? Yes / No
Have you had other tests, such as an echocardiogram or stress test? Yes / No If yes, was it normal? Yes / No

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

a. Heart attack: Yes / No If yes, when? _____ When was your last
b. Stroke: Yes / No If yes, when? _____ Did you fully recover? Yes / No If no, please explain:
_____

c. Angina: Yes / No If yes, when was the last time you had chest pain and what causes it?
_____
d. Heart failure: Yes / No If yes, when? _____
e. Swelling in your legs or feet (not caused by walking): Yes / No
f. Heart arrhythmia (heart beating irregularly): Yes / No If yes, please describe:
_____
g. High blood pressure: Yes / No
h. Any other heart problem that you have been told about: Yes / No

If you answered "yes" to any of these questions, please answer the following:
Have you had a stress test? Yes / No If yes, when was the last stress test? _____ Was the result normal? Yes / No
Have you had an echocardiogram? Yes / No If yes, when was the last echo? _____ Was the result normal? Yes / No
Have you had a Holter or event monitor? Yes / No If yes, was the result normal? Yes / No
Do you have a pacemaker or an internal defibrillator implant? Yes / No
Have you undergone heart or blood vessel surgery? Yes / No If yes, when? _____

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 If yes, describe: _____
e. Heartburn or indigestion that is not related to eating: Yes / No
f. Any other symptom that you think may be related to heart or circulation problems: Yes / No

If you answered "yes" to any of these questions, please answer the following:
Have you been evaluated by a doctor for these symptoms? Yes / No
Have you had a stress test? Yes / No If yes, when was the last stress test? _____ Was the result normal? Yes / No
Have you had an echocardiogram? Yes / No If yes, when was the last echo? _____ Was the result normal? Yes / No
Have you had a Holter or event monitor? Yes / No If yes, was the result normal? Yes / No
Do you have a pacemaker or an internal defibrillator implant? Yes / No
Have you undergone heart or blood vessel surgery? Yes / No If yes, when? _____

7. Do you **currently** take medications 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

If "yes" for any of these questions, please list your medications:
_____
_____
_____

8. If you have used a respirator, have you **ever had** any of the following problems?
(If you have never used a respirator, check the following box and go on to the next question)
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. Would you like to talk with the health care professional who will review this questionnaire about your answers to this questionnaire: Yes / No

10. Have you ***ever lost*** vision in either eye (temporarily or permanently): Yes / No If yes, have you recovered? Yes / No

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 If yes, please describe:

_____

12. Have you ***ever had*** an injury to your ears, including a broken ear drum: Yes / No If yes, have you recovered? Yes / No

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

14. Have you ***ever had*** a back injury: Yes / No If yes, when was the last back injury? _____ Have you fully recovered? Yes / No

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 and 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. 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 "yes" to any of these symptoms, what medications are you taking?

_____

Your (employee) signature: _____ Date: _____

Medical Reviewer signature: _____ Name (PRINT): _____ Date: