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Respirator Clearance Evaluation

New Hire _____
Annual _____
SCBA _____

Employer Information:

Employer: _____ **Job Title: _____**

Employee Contact Information:

Last Name: _____ First Name: _____ Middle Name: _____

Current Address: _____

City: _____ State: _____ Zip:_____

Current Phone : _____ *Email:_____

Sex: ☐ Male ☐ Female DOB: _____

* Email to be used to request call back to gather more information.

Note: Employee contact information will be used to register you into our secure electronic medical record.

Instructions:

Please fill out the OSHA Respirator Medical Evaluation Questionnaire to the best of your knowledge. If you answer yes to a question, please give additional details in the space provided next to the question and/or on the last page of the questionnaire. By giving complete answers on this questionnaire, it will greatly reduce the likelihood of needing to come to clinic for an evaluation by a healthcare provider.

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OSHA Respirator Medical Evaluation Questionnaire (Appendix C to Sec. 1910.134)

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 age** (to nearest year)**:** _____ **Date of birth:** _____
4. **Sex** (check one)**:** ☐ Male ☐ Female
5. **Your height:** _____ ft. _____ in.
6. **Your weight:** _____ lbs.
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?** (check one)**:** ☐ 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)
    - ☐ Half-facepiece
    - ☐ Full-facepiece
    - ☐ Powered-air purifying
    - ☐ Supplied-air
    - ☐ Self-contained breathing apparatus (SCBA)
    - ☐ Other type: _____
12. **Have you worn a respirator?** (check one)**:** ☐ Yes ☐ No

    If yes, what type(s)?
    - ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only)
    - ☐ Half-facepiece
    - ☐ Full-facepiece
    - ☐ Powered-air purifying
    - ☐ Supplied-air
    - ☐ Self-contained breathing apparatus (SCBA)
    - ☐ Other type: _____

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 check yes or no).

Yes	No	
☐	☐	**1. Do you currently smoke tobacco or have you smoked tobacco in the last month?**
		If yes, for how many years? ____ What type? _____ If cigarettes, how many packs per day? ____
		2. Have you <u>ever had</u> any of the following conditions?
☐	☐	**a) Seizures**
		If yes, when and what happened? _____
		When was your last seizure? _____ Describe current treatment: _____
☐	☐	**b) Diabetes (sugar disease)**
		If yes, what was your last HbA1c? _____ What are your usual blood sugar levels? _____
		Describe treatment (e.g. metformin, insulin): _____
		In the last year, have you required assistance from anyone due to low blood sugar? ☐ Yes ☐ No
		Do you have any problems with your heart, kidneys, eyes, or feet due to diabetes? ☐ Yes ☐ No
☐	☐	**c) Allergic reactions that interfere with your breathing**
		If yes, when and what happened? _____
		Does this prevent you from wearing a respirator or doing any part of your job? ☐ Yes ☐ No
☐	☐	**d) Claustrophobia (fear of closed-in places)**
		If yes, when and what happened? _____
		Does this prevent you from wearing a respirator or doing any part of your job? ☐ Yes ☐ No
☐	☐	**e) Trouble smelling odors**
		If yes, when and what happened? _____
		Does this prevent you from wearing a respirator or doing any part of your job? ☐ Yes ☐ No
		3. Have you <u>ever had</u> any of the following pulmonary or lung problems?
☐	☐	**a) Asbestosis**
		If yes, when? _____ Describe treatment: _____
☐	☐	**b) Asthma**
		If yes, when was your last asthma attack? _____ When did you last use an inhaler? _____
		Describe current treatment: _____
		What are your triggers for asthma attacks? _____
		Have you ever been to the emergency department due to asthma? ☐ Yes ☐ No If yes, when? _____
		Have you ever spent the night in the hospital due to asthma? ☐ Yes ☐ No If yes, when? _____

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Yes	No		
☐	☐	**c)**	**Chronic bronchitis**
			If yes, when? _____ Describe treatment: _____
☐	☐	**d)**	**Emphysema**
			If yes, when? _____ Describe treatment: _____
☐	☐	**e)**	**Pneumonia**
			If yes, when? _____ Describe treatment: _____
☐	☐	**f)**	**Tuberculosis**
			If yes, when? _____ Describe treatment: _____
☐	☐	**g)**	**Silicosis**
			If yes, when? _____ Describe treatment: _____
☐	☐	**h)**	**Pneumothorax (collapsed lung)**
			If yes, when? _____ Describe treatment: _____
☐	☐	**i)**	**Lung cancer**
			If yes, when? _____ Describe treatment: _____
☐	☐	**j)**	**Broken ribs**
			If yes, when? _____ Describe treatment: _____
☐	☐	**k)**	**Any chest injuries or surgeries**
			If yes, when? _____ Describe treatment: _____
☐	☐	**l)**	**Any other lung problem that you've been told about**
			If yes, please describe: _____

4. Do you <u>currently</u> have any of 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 or incline**
☐	☐	**c)**	**Shortness of breath when walking with other people at an ordinary pace on level ground**
☐	☐	**d)**	**Shortness of breath when washing or dressing yourself**
☐	☐	**e)**	**Shortness of breath that interferes with your job**
☐	☐	**f)**	**Coughing that produces phlegm (thick sputum)**
☐	☐	**g)**	**Coughing that wakes you early in the morning**
☐	☐	**h)**	**Coughing that occurs mostly when you are lying down**
☐	☐	**i)**	**Coughing up blood in the last month**
☐	☐	**j)**	**Wheezing**
☐	☐	**k)**	**Wheezing that interferes with your job**
☐	☐	**l)**	**Chest pain when you breathe deeply**
☐	☐	**m)**	**Any other symptoms that you think may be related to lung problems**
			If yes to any of the above, please describe: _____

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Yes	No	
		5. Have you <u>ever had</u> any of the following cardiovascular or heart problems?
☐	☐	**a) Heart attack**
		If yes, when? _____ Describe treatment: _____
		Do you have any current restrictions or limitations on your activities? ☐ Yes ☐ No
☐	☐	**b) Stroke**
		If yes, when? _____ Describe treatment: _____
		Do you have any current restrictions or limitations on your activities? ☐ Yes ☐ No
☐	☐	**c) Angina**
		If yes, when? _____ Describe treatment: _____
		Do you have any current restrictions or limitations on your activities? ☐ Yes ☐ No
☐	☐	**d) Heart failure**
		If yes, when? _____ Describe treatment: _____
		Do you have any current restrictions or limitations on your activities? ☐ Yes ☐ No
☐	☐	**e) Swelling in your legs or feet (not caused by walking)**
		If yes, when? _____ Describe treatment: _____
		Do you have any current restrictions/limitations on your activities? ☐ Yes ☐ No
☐	☐	**f) Heart arrhythmia (heart beating irregularly)**
		If yes, when? _____ Describe treatment: _____
		Do you have any current restrictions or limitations on your activities? ☐ Yes ☐ No
☐	☐	**g) High blood pressure**
		If yes, when? _____ Describe treatment: _____
		What are your usual blood pressure readings? _____
☐	☐	**h) Any other heart problem that you've been told about**
		If yes, please describe: _____
		6. Have you <u>ever had</u> any of the following cardiovascular or heart symptoms?
☐	☐	**a) Frequent pain or tightness in your chest**
		If yes, when and what happened? _____
☐	☐	**b) Pain or tightness in your chest during physical activity**
		If yes, when and what happened? _____
☐	☐	**c) Pain or tightness in your chest that interferes with your job**
		If yes, when and what happened? _____
☐	☐	**d) In the past two years, have you noticed your heart skipping or missing a beat**
		If yes, when and what happened? _____

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Yes	No	
☐	☐	**e) Heartburn or indigestion that is not related to eating** If yes, when and what happened? _____
☐	☐	**f) Any other symptoms that you think may be related to heart or circulation problems** If yes, when and what happened? _____
		7. Do you <u>currently</u> take medication for any of the following problems?
☐	☐	**a) Breathing or lung problems** If yes, list medications: _____
☐	☐	**b) Heart trouble** If yes, list medications: _____
☐	☐	**c) Blood pressure** If yes, list medications: _____
☐	☐	**d) Seizures** If yes, list medications: _____
		8. If you've used a respirator, have you <u>ever had</u> any of the following problems? (If you've never used a respirator, check the following space and go to question 9: ☐)
☐	☐	**a) Eye irritation** If yes, have you successfully used a respirator since this happened? ☐ Yes ☐ No
☐	☐	**b) Skin allergies or rashes** If yes, have you successfully used a respirator since this happened? ☐ Yes ☐ No
☐	☐	**c) Anxiety** If yes, have you successfully used a respirator since this happened? ☐ Yes ☐ No
☐	☐	**d) General weakness or fatigue** If yes, have you successfully used a respirator since this happened? ☐ Yes ☐ No
☐	☐	**e) Any other problem that interferes with your use of a respirator** If yes, please describe: _____
☐	☐	**9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?**

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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.

Yes	No	
☐	☐	**10. Have you <u>ever</u> lost vision in either eye (temporarily or permanently)?**
		If yes, when and what happened? _____
		11. Do you <u>currently</u> have any of the following vision problems?
☐	☐	**a) Wear contact lenses**
☐	☐	**b) Wear glasses**
☐	☐	**c) Color blind**
☐	☐	**d) Any other eye or vision problem**
		If yes, please describe: _____
☐	☐	**12. Have you <u>ever had</u> an injury to your ears, including a broken ear drum?**
		If yes, please describe: _____
		13. Do you <u>currently</u> have any of the following hearing problems?
☐	☐	**a) Difficulty hearing**
☐	☐	**b) Wear a hearing aid**
☐	☐	**c) Any other hearing or ear problem**
		If yes, please describe: _____
☐	☐	**14. Have you <u>ever</u> had a back injury?**
		If yes, when and what happened? _____
		Do you have any current restrictions or limitations on your activities? ☐ Yes ☐ No
		15. Do you <u>currently</u> have any of the following musculoskeletal problems?
☐	☐	**a) Weakness in any of your arms, hands, legs, or feet**
☐	☐	**b) Back pain**
☐	☐	**c) Difficulty fully moving your arms and legs**
☐	☐	**d) Pain or stiffness when you lean forward or backward at the waist**
☐	☐	**e) Difficulty fully moving your head up or down**
☐	☐	**f) Difficulty fully moving your head side to side**
☐	☐	**g) Difficulty bending at your knees**
☐	☐	**h) Difficulty squatting to the ground**
☐	☐	**i) Climbing a flight of stairs or a ladder carrying more than 25 pounds (lbs)**
☐	☐	**j) Any other muscle or skeletal problem that interferes with using a respirator**
		If yes to any of the above, please describe: _____

Additional space for use by employees, if needed:

To be completed by staff:

☐ Medically cleared for use of all respirators, <u>including</u> SCBA, subject to fit test.

☐ Medically cleared for use of all respirators, <u>excluding</u> SCBA, subject to fit test.

☐ Medically cleared for use of disposable and half-facepiece respirators, subject to fit test.

☐ Medically cleared for use of disposable respirators only, subject to fit test.

☐ <u>Not</u> medically cleared for use of respirators.

☐ Medical clearance is pending due to: _____

_____

Health Professional Reviewer: _____ Date Reviewed: _____

Date of exam: _____

EMPLOYEE COPY OF RESPIRATOR MEDICAL RECOMMENDATIONS

This form outlines the results of the OSHA Respirator Medical Evaluation. If you have any questions regarding this evaluation, please call Occupational Medicine at 952-883-6999.

Respirator Clearance Status:

- ☐ Medically cleared for use of all respirators, including SCBA, subject to fit test.
- ☐ Medically cleared for use of all respirators, excluding SCBA, subject to fit test.
- ☐ Medically cleared for use of disposable and half-facepiece respirators, subject to fit test.
- ☐ Not medically cleared for use of respirators.
- ☐ Medical clearance is pending due to: _____

_____

Health Professional Reviewer: _____ Date: _____