



OSHA Respirator Questionnaire

Employer Information

Employer Name: _____ Phone Number: _____

Employer Address: _____

Authorized Contact: _____ Fax: _____

Employee Information

Employee Name: _____ Phone Number: _____

Employee Birthdate: _____ Employee SSN #: _____

FOR OFFICE USE ONLY

Examination Requested:

- Respirator Medical Questionnaire
- Respirator Use Physical Exam

Examination Findings:

- He/She must call and schedule an appointment for a physical before decision can be made.
- He/She is **MEDICALLY APPROVED** to use a respirator.
- He/She is **NOT** medically approved to use a respirator.

Physicians Signature

Date

Can you read (mark one box): 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.

Completed questionnaires can be submitted online, or should be placed in a sealed envelope and delivered to:
**Primary Health Medical Group, Occupational Health Department, Attn: OSHA Respirator Review,
6052 W. State Street, Boise, ID 83703**

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: _____

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

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

9. Are you taking any medications currently (including over-the-counter medications): Yes No

If "yes," name the medications if you know them: _____

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

11. How often are you expected to use the respirator(s) (marke "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

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): _____

Part C. (Mandatory) *Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please mark the box "yes" or "no").*

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month: Yes No

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

a. Seizures (fits): Yes No

b. Diabetes (sugar disease): 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: Yes No

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

- | | | | |
|----|---|------------------------------|-----------------------------|
| a. | Asbestosis: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. | Asthma: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. | Chronic bronchitis: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. | Emphysema: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. | Pneumonia: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. | Tuberculosis: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. | Silicosis: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. | Pneumothorax (collapsed lung): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. | Lung cancer: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. | Broken ribs: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k. | Any chest injuries or surgeries: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| l. | Any other lung problem that you've been told about: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

- | | | | |
|----|---|------------------------------|-----------------------------|
| a. | Shortness of breath: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. | Shortness of breath when walking fast on level ground or walking up an incline: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. | Shortness of breath when walking at an ordinary pace on level ground: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. | Have to stop for breath when walking at your own pace on level ground: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. | Shortness of breath when washing or dressing yourself: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. | Shortness of breath that interferes with your job: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. | Coughing that produces phlegm (thick sputum): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. | Coughing that wakes you early in the morning: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. | Coughing that occurs mostly when you are lying down: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. | Coughing up blood in the last month: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k. | Wheezing: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| l. | Wheezing that interferes with your job: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| m. | Chest pain when you breathe deeply: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| n. | Any other symptoms that you think may be related to lung problems: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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
- 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

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/circulation problems: Yes No

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

8. If you've used a respirator, have you **ever had** any of the following problems? (If you've NEVER used a respirator, proceed to question 9)

- 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 to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes No

PART D. *The questions 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.*

1. Have you **ever lost** vision in either eye (temporarily or permanently): Yes No
2. 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
3. Have you **ever had** an injury to your ears, including a broken eardrum: Yes No
4. 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
5. Have you **ever had** a back injury: Yes No
6. 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. 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