MEMORIAL HERMANN

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 medical examination.

To the employee: Can you read (check 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. Todays date: _____
2. Your Name: _____
3. Your Age (to the nearest year): _____
4. Sex (Check One): ☐ Male ☐ Female
5. Your Height: _____Ft. _____In.
6. Your Weight: _____
7. Your Job Title: _____

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include area code): _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the heath 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):
    a. ☐ Disposable respirator (i.e., N95 or N100 (HEPA) TB respirator, half face respirator
    b. ☐ Other type (for example, full – facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus (SCBA). Check the approriate type(s).

12. Have you worn a respirator (check one): ☐ Yes ☐ No If "yes", what type(s): _____

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").

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. Absestosis ☐ 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. Other lung problems that you've been told about? ☐ Yes ☐ No

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

5. Have you **ever** had any of the following cardiovascular or heart problems?
   a. Heart attack: ☐ Yes ☐ No
   b. Swelling in your legs or feet (not caused by walking): ☐ Yes ☐ No
   c. Angina: ☐ Yes ☐ No
   d. High blood pressure: ☐ Yes ☐ No
   e. Stroke: ☐ Yes ☐ No
   f. Heart arrhythmia (heart beating irregularly) ☐ Yes ☐ No
   g. Heart failure: ☐ 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 or 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, (TB Mask) have you ever had any of the the following problems?
   (If you've never used a respirator, go 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

To the best of my knowledge, the information I have provided is true and accurate.

_____ _____

Employee Signature **Date**

Occupational Health Use Only

_____ Employee cleared for fit testing _____ Employee clearance pending medical director review.
_____ Employee referred to personal physician _____ Employee Clearance Pending HR Supervisor

____Failed ____ Pass _____Fit Factor **Signature:** _____ **Date**: ___/___/_____