GULF REGIONAL OCCUPATIONAL MEDICINE CENTER

BATON ROUGE LOCATION:
8742 Goodwood Blvd.
Baton Rouge, LA 70806
Phone #: 225-231-7070
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ABBEVILLE LOCATION:
121 East St. Victor St.
Abbeville, LA 70510
Phone #: 337-893-0810
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Company:___________________________________

Can you read (circle one) YES / NO

OSHA Respirator Medical Evaluation Questionnaire

CFR App. C to 1910.137, January 8, 1998

Before you answer this questionnaire ask your employer to give you information on: type or respirators you will use, for how long (hours/day, times/week), under what conditions (temp., humidity), and type of physical effort and other protective gear you will wear. Examples of physical effort are given under pat B item 12, page 4 (a sample information form is given below.

Information on your work conditions (please V as appropriate)

1. Type or respirator to used: Air Purifying _______, Air Supplied _______, Self-Contained _____, Other _______________ ____ Model & Series:_____________Weight:_____________________
2. Duration of work with respirators:__________hours/day: ___________ days/week Other:________________________
3. Expected physical work: Light________, Moderate _______ ,Heavy________, Other: ____________________________
4. Other additional protective gear or PPE you will wear:____
5. Working Conditions: Temperature__________, Humidity_________,
Other:____

** Your employer must allow you to answer this questionnaire during normal working hours, or at a time or 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.**

DO NOT FORGET TO SIGN BELOW THE STATEMENT SAYING THAT YOU HAVE ANSWERED THESE QUESTIONS TRUTHFULLY AT THE END OF THIS QUESTIONNAIRE, page 5

ALL PARTS OF THIS QUESTIONNAIRE MUST BE ANSWERED. QUESTIONS 10-15 OF PART A SECTION 2 ARE TO BE ANSWERED ONLY BE EMPLOYEES WHO WILL USE a *full-face piece respirator or a self-contained breathing apparatus (SCBA).*

Part A. Section 1: The following information must be provided by every employee who has been selected to use any type of respirator(please print and encircle Yes / No as necessary).

1. Today's date:_________________ 2. Your Name:____ 3. Your age:_______

4. Sex (Male / Female) 5. Your height:_________ 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 can reach you (include Area Code):_______________________ 9. Best time to call you at this number:_____________________

10. Has your employer told you how to contact the person who will review this questionnaire.
YES / NO

11. Check the type of respirator you will use (you can check more than one category):
A.____N.R. or P disposable respirator (filter-mask, non-cartridge type only). B._______ Other type (for example, half-or full face piece type, powered-air purifying, supplied air, self-contained breathing apparatus)

12. Have you worn a respirator? (circle one)YES / NO If "yes", what types:____________________________________
____

Please write your name here:______________________________

VERY IMPORTANT: *If your answer is yes to any of the question concerning your health in this questionnaire, you must describe them in detail answering theses questions: did you have the problem in the past or are you currently suffering from the problem? Is it under control now? Are you taking medications for it? Are you under a physician's supervision?*

Part A. Section 2: Questions 1 through 9 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
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

If "YES" please explain in detail:____
____

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

a. Asbestoses YES / NO	e. Silicosis YES / NO	i. Pneumothorax (collapsed lung) YES / NO
b. Asthma YES / NO	f. Lung Cancer YES / NO	j. Chronic bronchitis YES / NO
c. Emphysema YES / NO	g. Broken ribs YES /NO	k. Any chest injuries or surgeries YES / NO
d. Pneumonia YES / NO	h. Tuberculosis YES / NO	l. Any other lung problems you had YES / NO

If "YES" please explain in detail:____
____

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 past month YES / NO
   - k. Wheezing YES / NO
   - l. Wheezing that interferes with your job YES / NO
   - m. Chest pain when you breath deeply YES / NO
   - n. Any other symptoms that you think may be related to lung problems YES / NO

If "YES" please explain in detail____
____

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

IF "YES" please explain in detail:____
____

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

If "YES" please explain in detail:____
____

Please write your name here:________________________

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

If "YES" please explain in detail and list the name of medications:______________________________
____

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator check the following space and go to question 9) _____

a. Eye irritation YES / NO
b. Skin allergies or rashes YES / NO
d. General weakness or fatigue YES / NO
e. Anxiety YES / NO
c. Any other problem that interferes with your use of a respirator: YES / NO

If "YES" please explain in detail:____
____

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: YES / NO

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). Those who have been selected to use other types of respirators, answering these questions are voluntary.

10. Have you ever lost vision in either eye (temporarily or permanently) YES / NO

If "YES" please explain in detail:____
____

11. Do you currently have any of the following vision problems?

a. Wear contact lenses YES / NO
b. Wear glasses YES / NO
c. Color blindness YES / NO
d. Any other eye or vision problems YES / NO

If "YES" please explain in detail:____
____

12. Have you ever had an injury to your ears, including a broken ear drum? YES / NO

If "YES" please explain in detail:____

____

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 problems YES / NO

If "YES" please explain in detail:____

____

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

If "YES" please explain in detail:____

____

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 or 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 you 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" please explain in detail:____

____

Part B. Any of the following questions, and other questions not listed, maybe added tot eh questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In you present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen? YES / NO

If "YES" do you have feeling of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions? YES / NO

If "YES" please explain in detail:____

____

Please write your name here:______________________________

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? YES / NO

If "YES" name the chemicals if you know them:____

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 YES / NO

d. Beryllium YES / NO

e. Aluminum YES / NO

f. Coal YES / NO

g. Iron YES / NO

h. Tin YES / NO

j. Any other hazardous exp YES / NO

If "YES" to question describe these exposures. Did you have any problems with these exposures? Were you cleared for work after these exposures? Please explain:____

____

4. List any second jobs or side businesses you have:____
5. List you 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
If "YES", describe those exposures:____

____

10. Will you be using any of the following items with your respirator(s)?

a. HEPA filters YES / NO b. Canisters (e.g., gas masks) YES / NO c. Cartridges YES / NO

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

a. Escape only (no rescue) YES / NO
b. Emergency rescue only YES / NO
c. Less than 5 hrs per week YES / NO
d. Less than 2 hrs per day YES / NO
e. 2 to 4 hrs per day YES / NO
f. Over 4 hrs 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

Examples of light work effort are sitting while writing, typing, drafting, or preforming 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

Examples of moderate work effort are sitting while nailing or filing; diving a truck or bus in urban traffic, standing while nailing, drilling, performing assembly work, or transferring a moderate load (about 35 lbs) at true 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 (about 350 kcal per hour) YES / NO

Examples of heavy work are lifting a heavy load (about 50 lbs) from the floor to your waist or should; 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 clothing and/or equipment:____

____

14. Will you be working under hot conditions (temperature exceeding 77 degrees F) YES / NO
15. Will you be working under humid conditions YES / NO
16. Describe the work you'll will 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) (e.g., confined spaces, life threatening gases):____

____

Please write your name here:________________________

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're sing your respirator(s): Name of first toxic substance:_____________________________________

Estimated maximum exposure level per shift:___________________________________
Duration of exposure per shift:____
Name of second toxic substance:____
Estimated maximum exposure level per shift:___________________________________
Duration of exposure per shift:____
Name of third toxic substance:
Estimated maximum exposure level per shift:___________________________________
Duration of exposure per shift:____
Please write your name here:______________________________
Name 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 (e.g., rescue, security):____
____

NOW PLEASE GO BACK TO EACH PAGE AND SEE IF YOU HAVE ANSWERED ALL THE QUESTIONS

Employee Acknowledgment (YOU MUST READ and SIGN THIS STATEMENT)

I understand that not answering the above questions truthfully can threaten the safety of myself and others. Therefore, I hereby certify that to the best of my knowledge the answers I gave to the above questions on pages 1-4 are correct and I understand that any false statement or incorrect information may result in my termination and may forfeit my right to worker's compensation benefits under R.S>23:1207.1

Employee Name:____ S.S.#:__________________________________

Employee Signature:____ Date:___________________________

Please write name here:______________________________

Evaluation/Notes by health care professional who will review this questionnaire:

- ☐ No medical conditions were found/detected which can prevent the employee from using respiratory protection as described
- ☐ Medical conditions were found which can prevent the employee from routine use of respiratory protection
- ☐ Medical conditions allow only for escape route or emergency use of respirators
- ☐ Medical evaluation is necessary before routine use of respiratory protection

____
____
____
____
____
____

Name & Signature:______________________________________

Date:____________________

Health Care Professional

If Respirator fit test is done, please fill out the following part:

Type of Mask fitted & Manufacturer	Size ______	Fit Factor ______________
1. ________________	________	____________________
2. ________________	________	____________________
3. ________________	________	____________________

Other Tests ____

____

____

____

Technician Signature   Date