ThedaCare At Work

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OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

If you have any questions, contact ThedaCare At Work
Mail or fax completed forms to ThedaCare At Work - Occupational Health,
2809 N. Park Drive Lane / Appleton, Wisconsin 54911 / Fax 920 380 4961

***To the employee**:* *Can you read (check yes or no):* ☐ **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. Today's date:_____ (month/day/year) Company Name:_____

2. Your name:_____ Social Security #: _____ - _____ - _____

3. Your address:_____

4. DOB/Age:_____/_____ **5.** Sex: ☐Male / ☐Female **6.** Your height: _____ ft _____ in (to nearest year)

7. Your weight: _____ pounds **8.** Your job title:_____

9. A phone number where you can be reached by the healthcare professional who reviews this questionnaire (include the Area Code): (____) _____ - _____ **10.** Best time to phone you at this number: _____

11. Has your employer told you how to contact the healthcare professional who will review this questionnaire (check yes or no): ☐ **Yes** ☐ **No**

12. 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- or full-face piece type, powered-air purifying, supplied-air
☐ Self-contained breathing apparatus (SCBA)

Have you worn a respirator? ☐**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?

Seizures (fits)	☐ YES ☐NO	Claustrophobia (fear of closed in places)	☐ YES ☐NO
Diabetes (sugar disease)	☐ YES ☐NO	Trouble smelling odors	☐ YES ☐NO
Allergic reactions that interfere with your breathing	☐YES ☐NO		

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

Asbestosis	☐ YES ☐NO	Silicosis	☐ YES ☐NO
Asthma	☐ YES ☐NO	Pneumothorax (collapsed lung)	☐ YES ☐NO
Chronic Bronchitis	☐ YES ☐NO	Lung Cancer	☐ YES ☐NO
Emphysema	☐ YES ☐NO	Broken Ribs	☐ YES ☐NO
Pneumonia	☐ YES ☐NO	Any chest injuries or surgeries	☐ YES ☐NO
Tuberculosis	☐ YES ☐NO	Any other lung problem that you've been told about	☐ YES ☐NO

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

Shortness of Breath	☐ YES ☐NO
Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐ YES ☐NO
Shortness of breath when walking with other people at an ordinary pace on level ground	☐ YES ☐NO
Have to stop for breath when walking at your own pace on level ground	☐ YES ☐NO
Shortness of breath when washing or dressing yourself	☐ YES ☐NO
Shortness of breath that interferes with your job	☐ YES ☐NO
Coughing that produces phlegm (thick sputum)	☐ YES ☐NO
Coughing that wakes you early in the morning:	☐ YES ☐NO
Coughing that occurs mostly when you are lying down:	☐ YES ☐NO
Coughing up blood in the last month:	☐ YES ☐NO
Wheezing	☐ YES ☐NO
Wheezing that interferes with your job:	☐ YES ☐NO
Chest pain when you breathe deeply:	☐ YES ☐NO
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?

Heart attack	☐ YES ☐NO	Swelling in your legs or feet (not caused by walking)	☐ YES ☐NO
Stroke	☐ YES ☐NO	Heart arrhythmia (heart beating irregularly)	☐ YES ☐NO
Angina	☐ YES ☐NO	High blood pressure	☐ YES ☐NO
Heart Failure	☐ YES ☐NO	Any other heart problem that you have been told about	☐ YES ☐NO

6. Have you ever had any of the following cardiovascular or heart symptoms?

Frequent pain or tightness in your chest	☐ YES ☐NO	In the past two years have you noticed your heart skipping or missing a beat	☐ YES ☐NO
Pain or tightness in your chest during physical activity	☐ YES ☐NO	Heartburn or indigestion that is not related to eating	☐ YES ☐NO
Pain or tightness in your chest that interferes with your job	☐ YES ☐NO	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?

Breathing or Lung Problems	☐ YES ☐NO	Blood Pressure	☐ YES ☐NO
Heart Trouble	☐ YES ☐NO	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, go to question 9)

Eye Irritation	☐ YES ☐NO	General weakness or fatigue	☐ YES ☐NO
Skin Allergies or Rashes	☐ YES ☐NO	Any other problem that interferes with your use of a respirator	☐ YES ☐NO
Anxiety	☐ 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**