OSHA medical evaluation questionnaire for respirator use and instructions for filling it out

When OSHA requires a respirator, the employee must fill out a questionnaire as part of the medical evaluation.

EMPLOYEE INSTRUCTIONS FOR FILLING OUT RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (MEQ)

Attached is a medical evaluation questionnaire for you to fill out. The OSHA standard requires that any employee who wears a respirator must be medically evaluated to ensure the safety and health of the employee. Your answers to this questionnaire will be kept confidential. Your employer does not have the right to view your
answers.

A physician or licensed health care professional (PLHCP) will review the questionnaire. If you have any questions about the questionnaire or concerns about respirator use and your health, you can call the PLHCP ____________________ at (_______) -- (___________________)

It is essential that you answer every question.
If you need assistance, please contact the PLHCP listed above.

If the PLHCP has any questions for you, s/he must be able to contact you. It is important that you include your home phone number and a time that you can be reached at home.

If you answer "yes" to any of the questions, please include any comments you might think important in helping the doctor evaluate your answers. (For example, if you have ever had pneumonia, note how long ago, or if you have high blood pressure, note if you are seeing a physician or taking medication to control it.) You can make notes near the question or on the back of the last page of this questionnaire.

The PLHCP may determine that a physical examination is necessary in order to better assess your ability to use a respirator. If so, your employer is required to provide you with a confidential medical examination at no cost to you.

The PLHCP will send a letter to you and your employer indicating if you are cleared for respirator use.

Thank you for your cooperation.

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OSHA Respirator Medical Evaluation Questionnaire

To the employee: Can you read English (circle 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. Today's date:____

2. Last name:______________________ First name:___________________

3. Age (to nearest year):__________

4. Sex (circle one): Male Female

5. Height:__________ ft. __________ in.

6. Weight: __________lbs.

7. 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 reach you at this number____________________

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes No

11. Check the type of respirator you will use (you can check more than one category):
a.______ Disposable respirator N, R, or P (filter-mask, non-cartridge type only).
b.______ Other (for example, half or full-facepiece, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you ever worn a respirator in the past: 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 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: Yes No
b. Diabetes (sugar disease):
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: 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. 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?
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 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. 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 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: 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, check the following space and 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

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece 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.

10. Have you ***ever lost*** vision in either eye (temporarily or permanently): Yes No

11. 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

12. Have you ***ever had*** an injury to your ears, including a broken eardrum: Yes No

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 problem: Yes No

14. Have you ***ever had*** a back injury: Yes No

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 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

Part B: Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. Describe the work you'll be doing while you're using your respirator:

____

____

2. Will you be using any of the following items with your respirator?

a. HEPA Filters (pink, red):	Yes	No
b. Canisters (for example, gas masks):	Yes	No
c. Cartridges:	Yes	No

3. How often are you expected to use the respirator (circle "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

4. During the period you are using the respirator, is your work effort:

a. ***Light***: [e.g., sitting while typing or writing; performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.] Yes No

If "yes," how long does this period last during the average shift:______ hrs._____mins.

b. ***Moderate***: [e.g., sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, or assembling a moderate load (about 35 lbs.) at trunk level; walking; pushing a wheelbarrow with heavy load (about 100 lbs.) on a level surface.] Yes No

If "yes," how long does this period last during the average shift:_______hrs._____mins.

c. ***Heavy***: [e.g., 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 8º grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).] Yes No

If "yes," how long does this period last during the average shift:_______hrs._____mins.

5. 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:

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6. Describe any special or hazardous conditions you might encounter when you're using your respirator (e.g., confined spaces, life-threatening gases):

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7. List the hazardous substances that you work with while wearing a respirator:

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8. Describe any special responsibilities you'll have while using your respirator that may affect the safety and well-being of others (e.g. rescue, security):

___

___

___

9. 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. Beryllium:	Yes	No
d. Tungsten/cobalt:	Yes	No
e. Aluminum:	Yes	No
f. Coal (for example, mining):	Yes	No
g. Iron:	Yes	No
h. Dusty environments:	Yes	No
i. Tin:	Yes	No
j. Solvents (e.g. paints, lacquers)	Yes	No
k. Any other hazardous exposures:	Yes	No

If "yes," describe these exposures:

___

___

___

10. At home have you been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or had skin contact with hazardous chemicals:
If "yes," name the chemicals if you know them:

___

___

___

11. List any second jobs or side businesses you have:

___

___

___

12. 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

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