UNIVERSITY OF WYOMING

APPENDIX F
OSHA Respiratory Protection Medical Evaluation Questionnaire

To the Supervisor: Answers to questions in Section 1, and to question 9 in Section 2 of Part A do not require a medical examination.

To be Completed by Employee:

Check "Yes" or "No" for the following questions:	**Yes**	**No**
Can you read?	☐	☐
Do you understand that: 1. Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient for you; 2. You are not required to share this form with your Supervisor and your Supervisor is not permitted to review your answers; and 3. Your employer will tell you how to provide this form to the physician or other licensed health care professional who will review and maintain the medical information?	☐	☐

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).

Your name:	Today's date:
Gender: ☐ Male ☐ Female	Your age (to the nearest year):
Your height: _____ feet _____ inches	Your weight: _____ lbs.
Your job title:	
A phone number where you can be reached by the healthcare professional who reviews this questionnaire (include area code):	
The best time to phone you at this number:	

	Yes	**No**
Has your employer told you how to contact the healthcare professional who reviews this questionnaire?	☐	☐

Check the type of respirator you will use (you may check more than one category):

☐ N, R, or P disposable respirator (filtering facepiece, non-cartridge type only)

☐ Other type (for example: half or full-face piece type, powered air-purifying, supplied-air, self-contained breathing apparatus)

	Yes	**No**
Have you ever worn a respirator?	☐	☐

If you answered "Yes", what type(s)?

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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 mark "yes" or "no").

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” in response to the following questions.	Yes	No
1. Do you ***currently*** smoke tobacco, or have you smoked tobacco in the last month?	☐	☐
2. Have you *ever had* any of the following conditions?		
a. Seizures (fits)	☐	☐
b. Diabetes (sugar disease)	☐	☐
c. Allergic reactions that interfere with your breathing	☐	☐
d. Claustrophobia (fear of closed-in spaces)	☐	☐
e. Trouble smelling odors	☐	☐
3. Have you ***ever had*** any of the following pulmonary or lung problems?		
a. Asbestosis	☐	☐
b. Asthma	☐	☐
c. Emphysema	☐	☐
d. Pneumonia	☐	☐
e. Tuberculosis	☐	☐
f. Silicosis	☐	☐
g. Pneumothorax (collapsed lung)	☐	☐
h. Lung cancer	☐	☐
i. Broken ribs	☐	☐
j. Any chest injuries or surgeries	☐	☐
k. Any other lung problem that you have been told about	☐	☐
4. Do you ***currently*** have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground	☐	☐
d. Have to stop for breath when walking at your own pace on level ground	☐	☐
e. Shortness of breath when washing or dressing yourself	☐	☐
f. Shortness of breath that interferes with your job	☐	☐
g. Coughing that produces phlegm (thick sputum)	☐	☐
h. Coughing that wakes you early in the morning	☐	☐
i. Coughing that occurs mostly when you are laying down	☐	☐
j. Coughing up blood in the last month	☐	☐
k. Wheezing	☐	☐
l. Wheezing that interferes with your job	☐	☐
m. Chest pain when you breathe deeply	☐	☐
n. Any other symptoms that you think may be related to lung problems	☐	☐

5.	Have you ***ever had*** any of the following cardiovascular or heart symptoms?	**Yes**	**No**
	a. Heart attack	☐	☐
	b. Stroke	☐	☐
	c. Angina	☐	☐
	d. Heart failure	☐	☐
	e. Swelling in your legs or feet (not caused by walking)	☐	☐
	f. Heart arrhythmia (heart beating irregularly)	☐	☐
	g. High blood pressure	☐	☐
	h. Any other heart problem that you've been told about	☐	☐
6.	Have you ***ever had*** any of the following cardiovascular or heart symptoms?		
	a. Frequent pain or tightness in your chest	☐	☐
	b. Pain or tightness in your chest during physical activity	☐	☐
	c. Pain or tightness in your chest that interferes with your job	☐	☐
	e. Noticing your heart skipping or missing a beat within the last two years	☐	☐
	f. Heartburn or indigestion that is not related to eating	☐	☐
	g. Any other symptoms that you think may be related to heart or circulation problems:	☐	☐
7.	Do you ***currently*** take medication for any of the following problems?		
	a. Breathing or lung problems	☐	☐
	b. Heart trouble	☐	☐
	c. Blood pressure	☐	☐
	e. Seizures	☐	☐
8.	If you have used a respirator, have you ***ever had*** any of the following problems (If you have never used a respirator, please check no and proceed to question 9)?	**Yes** ☐	**No** ☐
	a. Eye irritation	☐	☐
	b. Skin allergies or rashes	☐	☐
	c. Anxiety	☐	☐
	d. General weakness or fatigue	☐	☐
	e. Any other problem that interferes with your use of a respirator	☐	☐
9.	Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire?	**Yes** ☐	**No** ☐

Questions 10 through 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)**. For employees who have been selected to use other types of respirators, answering these questions is voluntary.	**Yes**	**No**
10. Have you ***ever lost*** vision in either eye (temporarily or permanently)?	☐	☐
11. Do you ***currently*** have any of the following vision problems?		
a. Wear contact lenses	☐	☐
b. Wear glasses	☐	☐
c. Color blind	☐	☐
d. Any other eye or vision problem	☐	☐
12. Have you ***ever had*** an injury to your ears, including a broken eardrum?	☐	☐
13. Do you ***currently*** have any of the following hearing problems?		
a. Difficulty hearing	☐	☐
b. Wearing a hearing aid	☐	☐
c. Any other hearing or ear problems?	☐	☐
14. Have you ***ever had*** a back injury?	☐	☐
15. Do you ***currently*** have any of the following musculoskeletal problems?		
a. Weakness in any of your arms, hands, legs or feet	☐	☐
b. Back pain	☐	☐
c. Difficulty moving your arms and legs	☐	☐
d. Pain or stiffness when you lean forward or backward at the waist	☐	☐
e. Difficulty fully moving your head up or down		
f. Difficulty fully moving your head side to side	☐	☐
g. Difficulty bending at your knees	☐	☐
h. Difficulty squatting to the ground	☐	☐
i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.	☐	☐
j. Any other muscle or skeletal problem that interferes with using a respirator	☐	☐

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.

		Yes	No
1.	In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen?	☐	☐
	If you answered "Yes" to the above, do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when working under these conditions?	☐	☐
2.	At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (i.e., gases, fumes, or dusts), or have you come into skin contact with hazardous chemicals?	☐	☐
	If you answered "Yes" to the above, please 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?	**Yes**	**No**
	a. Asbestos	☐	☐
	b. Silica (i.e., sandblasting)	☐	☐
	c. Tungsten/cobalt (i.e., grinding or welding this material)	☐	☐
	d. Beryllium	☐	☐
	e. Aluminum	☐	☐
	f. Coal (i.e., mining)	☐	☐
	g. Iron	☐	☐
	h. Tin	☐	☐
	i. Dusty environments	☐	☐
	j. Any other hazardous exposures	☐	☐
If "yes", please describe these exposures:			
4.	List any second jobs or side business you have:		
5.	List your previous occupations:		
6.	List your current and previous hobbies:		

7.	Have you ever been in the military service?	**Yes** ☐	**No** ☐
	If you answered "Yes" to the above, were you exposed to biological or chemical agents (either in training or in combat)?	☐	☐
8.	Have you ever worked on a HAZMAT team?	☐	☐
9.	Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)?	☐	☐
	If "yes", please name the medications if you know them:		
10.	Will you be using any of the following items with your respirator(s)?	**Yes**	**No**
	a. HEPA filters	☐	☐
	b. Canisters	☐	☐
	c. Cartridges	☐	☐
11.	How often are you expected to use the respirator(s) (Please check all boxes that apply to you)?		
	a. Escape only	☐	
	b. Emergency rescue only	☐	
	c. Less than 5 hours **per week**	☐	
	d. Less than 2 hours **per day**	☐	
	e. 2 to 4 hours per day	☐	
	f. Over 4 hours per day	☐	
12.	During the period you are using the respirator(s), is your work effort (please check the one closest to your type of work while using a respirator):		
	a. **Light** (less than 200 kcal per hour). 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.	☐	
	If above box is checked, how long does this period last during the average shift? _____ hrs _____ min		
	b. **Moderate** (200 to 350 kcal per hour). 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 at about 2 mph or down a 5-degree grade at about 3 mph; or **pushing** a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.	☐	
	If above box is checked, how long does this period last during the average shift? _____ hrs _____ min		
	c. **Heavy** (about 350 kcal per hour). Examples of heavy work effort 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 at about 2 mph; or climbing stairs with a heavy load (about 50 lbs.).	☐	
	If above box is checked, how long does this period last during the average shift? _____ hrs _____ min		

13.	Will you be wearing protective clothing and/or equipment (other than the respirator when you are using your respirator?	**Yes** ☐	**No** ☐
	If "yes", please describe this protective clothing and/or equipment:		
14.	Will you be working under hot conditions (temperatures exceeding 77ºF)?	**Yes** ☐	**No** ☐
15.	Will you be working under humid conditions?	**Yes** ☐	**No** ☐
16.	Describe the work you will be doing while you are using your respirator(s):		
17.	Describe any special or hazardous conditions you might encounter when you are using your respirators(s) (i.e., confined spaces, life-threatening gases):		
18.	Provide the following information, if you know it, for each toxic substance that you will be exposed to while wearing 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 will be exposed to while using your respirator(s):	

19.	Describe any special responsibilities you will have while using your respirator(s) that may affect the safety and wellbeing of others (i.e., rescue, security, etc.):		
20.	By completing this form, you agree that the medical information you provide on this form can be reviewed by a University of Wyoming health care professional and/or a physician or other licensed healthcare professional. This information will be maintained in your medical files.	**Yes** ☐	**No** ☐

Thank you for completing this form.

Please note: This document is confidential. Do not share with anyone other than the physician or other licensed health care professional (PLHCP). Do not forward a copy to your Supervisor or to the Program Administrator. Please provide this completed document to the PLHCP.