

Yale Health Center  
55 Lock Street  
PO Box 208237  
New Haven, CT. 06520  
203-432-0071

## **Department of Employee Health OSHA Respirator Medical Evaluation Questionnaire**

Please note: This form will be reviewed by the Department of Employee Health (see Part A, Section I, Question 10). If you have any questions, please contact the Department of Employee Health at 203-432-0071.

If you would like to complete this form electronically, visit  
<https://ehs.yale.edu/sites/default/files/files/respirator-medical-questionnaire.pdf>

Please upload the completed form to:  
<https://healthontrack.yale.edu>

For Employee Health Use Only			
	N95/100		Full Face Neg Press
	PAPR		SCBA
	½ Face Neg Press		Airline Resp

**To The Employer:**

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

**To The Employee:**

Can you read?  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 healthcare professional who will review it.*

PART A, Section I (Mandatory)	
The following information must be provided by every employee who has been selected to use any type of respirator.	
1.) Today's Date:	
2.) Your Name:	
3.) Your age (to nearest year):	4.) Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
5.) Your height:                      ft.                      in.	6.) Your weight:                      lbs.
7.) Your job title:	
8.) Phone number you can be reached by healthcare professional who reviews this questionnaire (including area code):	
9.) Best time to phone you at this number:	
10.) Has your employer told you how to contact the healthcare professional who will review this questionnaire? <input type="checkbox"/> Yes <input type="checkbox"/> No	
11.) Check the type of respirator you will use (you can check more than one category): <input type="checkbox"/> N,R or P disposable respirator (filter-mask, non-cartridge type only) <input type="checkbox"/> Other type (example: half-or full-face piece type, powered air purifying, supplied-air, self-contained breathing apparatus)	
12.) Have you worn a respirator? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what types(s):	

**Part A, Section II (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.) 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 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.) 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

**Part A, Section II (Continued)**

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 used a respirator, have you ever had any of the following problems? If you have never used a respirator, check here  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 healthcare professional who will review this questionnaire regarding your answers.....  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).***

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 problems.....  Yes  No

12.) Have you ever had an injury to your ears, including a broken ear drum?.....  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 full 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**

1.) 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 materials?... Yes No

If yes, name the chemicals if you know them:

2.) Have you ever worked with any of the materials, or under any of the conditions listed below?

- a.) Absestos..... Yes No
- b.) Silica (e.g., in sandblasting)..... Yes No
- c.) Tungsten/cobalt (e.g., grinding or welding this material)..... Yes No
- d.) Beryllium..... Yes No
- e.) Aluminum..... Yes No
- f.) Coal (e.g., mining)..... Yes No
- g.) Iron..... Yes No
- h.) Tin..... Yes No
- i.) Dusty environments..... Yes No
- j.) Any other hazardous exposures (if yes, describe the exposures)..... Yes No

3.) List any second jobs or side businesses you have:

4.) List your previous occupations:

5.) List your current and previous hobbies:

6.) 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

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

8.) 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)?..... Yes No

If yes, name the medications if you know them:

**Part B (Continued)**

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

- a.) HEPA filters.....  Yes  No
- b.) Canisters (for example, gas masks).....  Yes  No
- c.) Cartridges.....  Yes  No

10.) How often are you expected to use the respirator(s) (check all that apply)?

- 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

11.) During the period you are using the respirator(s), is your work effort (check one):

- Light     Moderate     Heavy

12.) When you are using your respirator, will you be wearing protective clothing and/or equipment (other than the respirator).....  Yes  No

If yes, describe the protective clothing and/or equipment:

13.) Will you be working under hot conditions (temperature exceeding 77 degrees)?.....  Yes  No

14.) Will you be working under humid conditions?.....  Yes  No

15.) Describe the work you will be doing while using your respirator(s):

16.) Describe any special or hazardous conditions you might encounter when you are using your respirator(s) (for example, confined spaces, life-threatening gases):

Signature:

Date:

Date of birth:

NetID

**Employer's Information**

Type of respirator:

Weight of respirator:

Expected physical work effort when respirator is in use:

Additional protective equipment to be worn:

Please note any extreme of temperature or humidity: