COUNTY OF LOS ANGELES
CHIEF EXECUTIVE OFFICE
OCCUPATIONAL HEALTH PROGRAMS

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Name:_____ **Employee Number**_____
Last First Initial.

Job Title:_____ **Item #**_____

To the Employee:

Can you read English? Yes ____
No ____ If "No" who helped you to understand and complete this questionnaire?
Name_____ Relationship_____

Your employer must allow you to answer the 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.

Section 1. 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. Sex (circle one) Male Female
3. Your height_____ft._____inch.
4. Your weight:_____lbs.
5. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the area code): _____
6. The best time to phone you at this number:_____
7. Has your employer told you how to contact the health care professional who will review this questionnaire?
   Yes _____ No_____
8. Check the type of respirator you will use (you can check more than one category)
   ____ N, R, or P disposable (filter-mask, non-cartridge type only)
   ____ Other type (for example, half or full-facepiece type, powered air purifying, supplied-air, SCBA)
9. Have you worn a respirator? Yes_____ No_____
   If "Yes," what type(s)?_____

Section 2. Please answer each question by circling "Yes" or "No"

Yes No **1. Do you currently smoke tobacco, or have you smoked tobacco in the past month?**

2. Have you ever had any of the following conditions?

Yes No 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

Name: _____

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

Yes No 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 (Please describe)

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

Yes No 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 you think may be related to lung problems (Please describe)

5. Have you ever had any of the following cardiovascular or heart problems?

Yes No 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. (Please describe)

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

Yes No 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? (Please describe)

7. Do you currently take medication for any of the following problems?

Yes No a. Breathing or lung problems
Yes No b. Heart trouble
Yes No c. Blood pressure
Yes No d. Seizures (fits)

Name: _____

Yes No **8. Have you used a respirator before?**

If "No" please skip to question #9. If "Yes", have you ever had any of the following problems?

Yes No 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 (Please describe)

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 **10. Have you ever lost vision in either eye (temporarily or permanently)**

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

Yes No a. Wear contact lenses
Yes No b. Wear glasses
Yes No c. Color blind
Yes No d. Any other eye or vision problem (Please describe)

Yes No **12. Have you ever had an injury to your ears, including a broken ear drum?**

13. Do you currently have any of the following hearing problems?

Yes No a. Difficulty hearing
Yes No b. Wear a hearing aid
Yes No c. Any other hearing or ear problem (Please describe)

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

15. Do you currently have any of the following musculoskeletal problems?

Yes No 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 and 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 from side to side
Yes No g. Difficulty bending at your knees
Yes No h. Difficulty squatting to the ground
Yes No I. Difficulty 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 (Please describe)

If you need to describe a problem in more detail, please use the space below (please write the question #)
