



## Respirator Clearance Evaluation

New Hire \_\_\_\_\_  
Annual \_\_\_\_\_  
SCBA \_\_\_\_\_

### Employer Information:

Employer: _____	Job Title: _____
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### Employee Contact Information:

Last Name: _____	First Name: _____	Middle Name: _____
Current Address: _____		
City: _____	State: _____	Zip: _____
Current Phone : _____	*Email: _____	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB: _____	
* Email to be used to request call back to gather more information.		

**Note: Employee contact information will be used to register you into our secure electronic medical record.**

### Instructions:

Please fill out the OSHA Respirator Medical Evaluation Questionnaire to the best of your knowledge. If you answer yes to a question, please give additional details in the space provided next to the question and/or on the last page of the questionnaire. By giving complete answers on this questionnaire, it will greatly reduce the likelihood of needing to come to clinic for an evaluation by a healthcare provider.
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## OSHA Respirator Medical Evaluation Questionnaire (Appendix C to Sec. 1910.134)

**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. **Your name:** \_\_\_\_\_
3. **Your age** (to nearest year): \_\_\_\_\_ **Date of birth:** \_\_\_\_\_
4. **Sex** (check one):  Male  Female
5. **Your height:** \_\_\_\_\_ ft. \_\_\_\_\_ in.
6. **Your weight:** \_\_\_\_\_ lbs.
7. **Your job title:** \_\_\_\_\_
8. **A phone number where you can be reached by the health care professional who reviews this questionnaire:**  
(include the Area Code): ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_
9. **The best time to phone you at this number:** \_\_\_\_\_
10. **Has your employer told you how to contact the health care professional who will review this questionnaire?**  
(check one):  Yes  No
11. **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-facepiece
  - Full-facepiece
  - Powered-air purifying
  - Supplied-air
  - Self-contained breathing apparatus (SCBA)
  - Other type: \_\_\_\_\_
12. **Have you worn a respirator?** (check one):  Yes  No  
If yes, what type(s)?
  - N, R, or P disposable respirator (filter-mask, non-cartridge type only)
  - Half-facepiece
  - Full-facepiece
  - Powered-air purifying
  - Supplied-air
  - Self-contained breathing apparatus (SCBA)
  - Other type: \_\_\_\_\_

**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).**

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>1. Do you currently smoke tobacco or have you smoked tobacco in the last month?</b> If yes, for how many years? ____ What type? _____ If cigarettes, how many packs per day? ____
<input type="checkbox"/>	<input type="checkbox"/>	<b>2. Have you <u>ever had</u> any of the following conditions?</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>a) Seizures</b> If yes, when and what happened? _____ When was your last seizure? _____ Describe current treatment: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>b) Diabetes (sugar disease)</b> If yes, what was your last HbA1c? _____ What are your usual blood sugar levels? _____ Describe treatment (e.g. metformin, insulin): _____ In the last year, have you required assistance from anyone due to low blood sugar? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any problems with your heart, kidneys, eyes, or feet due to diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<b>c) Allergic reactions that interfere with your breathing</b> If yes, when and what happened? _____ Does this prevent you from wearing a respirator or doing any part of your job? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<b>d) Claustrophobia (fear of closed-in places)</b> If yes, when and what happened? _____ Does this prevent you from wearing a respirator or doing any part of your job? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<b>e) Trouble smelling odors</b> If yes, when and what happened? _____ Does this prevent you from wearing a respirator or doing any part of your job? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<b>3. Have you <u>ever had</u> any of the following pulmonary or lung problems?</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>a) Asbestosis</b> If yes, when? _____ Describe treatment: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>b) Asthma</b> If yes, when was your last asthma attack? _____ When did you last use an inhaler? _____ Describe current treatment: _____ What are your triggers for asthma attacks? _____ Have you ever been to the emergency department due to asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ Have you ever spent the night in the hospital due to asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>c) Chronic bronchitis</b> If yes, when? _____ Describe treatment: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>d) Emphysema</b> If yes, when? _____ Describe treatment: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>e) Pneumonia</b> If yes, when? _____ Describe treatment: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>f) Tuberculosis</b> If yes, when? _____ Describe treatment: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>g) Silicosis</b> If yes, when? _____ Describe treatment: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>h) Pneumothorax (collapsed lung)</b> If yes, when? _____ Describe treatment: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>i) Lung cancer</b> If yes, when? _____ Describe treatment: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>j) Broken ribs</b> If yes, when? _____ Describe treatment: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>k) Any chest injuries or surgeries</b> If yes, when? _____ Describe treatment: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>l) Any other lung problem that you've been told about</b> If yes, please describe: _____
<b>4. Do you <u>currently</u> have any of the following symptoms of pulmonary or lung illness?</b>		
<input type="checkbox"/>	<input type="checkbox"/>	<b>a) Shortness of breath</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>b) Shortness of breath when walking fast on level ground or walking up a slight hill or incline</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>c) Shortness of breath when walking with other people at an ordinary pace on level ground</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>d) Shortness of breath when washing or dressing yourself</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>e) Shortness of breath that interferes with your job</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>f) Coughing that produces phlegm (thick sputum)</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>g) Coughing that wakes you early in the morning</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>h) Coughing that occurs mostly when you are lying down</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>i) Coughing up blood in the last month</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>j) Wheezing</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>k) Wheezing that interferes with your job</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>l) Chest pain when you breathe deeply</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>m) Any other symptoms that you think may be related to lung problems</b>
		If yes to any of the above, please describe: _____

Yes	No
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**5. Have you ever had any of the following cardiovascular or heart problems?**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>a) Heart attack</b></p> <p>If yes, when? _____ Describe treatment: _____</p> <p>Do you have any current restrictions or limitations on your activities? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>b) Stroke</b></p> <p>If yes, when? _____ Describe treatment: _____</p> <p>Do you have any current restrictions or limitations on your activities? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>c) Angina</b></p> <p>If yes, when? _____ Describe treatment: _____</p> <p>Do you have any current restrictions or limitations on your activities? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>d) Heart failure</b></p> <p>If yes, when? _____ Describe treatment: _____</p> <p>Do you have any current restrictions or limitations on your activities? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>e) Swelling in your legs or feet (not caused by walking)</b></p> <p>If yes, when? _____ Describe treatment: _____</p> <p>Do you have any current restrictions/limitations on your activities? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>f) Heart arrhythmia (heart beating irregularly)</b></p> <p>If yes, when? _____ Describe treatment: _____</p> <p>Do you have any current restrictions or limitations on your activities? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>       |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>g) High blood pressure</b></p> <p>If yes, when? _____ Describe treatment: _____</p> <p>What are your usual blood pressure readings? _____</p>  |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>h) Any other heart problem that you've been told about</b></p> <p>If yes, please describe: _____</p>   |

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

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>a) Frequent pain or tightness in your chest</b></p> <p>If yes, when and what happened? _____</p>                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>b) Pain or tightness in your chest during physical activity</b></p> <p>If yes, when and what happened? _____</p>                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>c) Pain or tightness in your chest that interferes with your job</b></p> <p>If yes, when and what happened? _____</p>                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <p><b>d) In the past two years, have you noticed your heart skipping or missing a beat</b></p> <p>If yes, when and what happened? _____</p> |

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>e) Heartburn or indigestion that is not related to eating</b> If yes, when and what happened? _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>f) Any other symptoms that you think may be related to heart or circulation problems</b> If yes, when and what happened? _____
<b>7. Do you <u>currently</u> take medication for any of the following problems?</b>		
<input type="checkbox"/>	<input type="checkbox"/>	<b>a) Breathing or lung problems</b> If yes, list medications: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>b) Heart trouble</b> If yes, list medications: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>c) Blood pressure</b> If yes, list medications: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>d) Seizures</b> If yes, list medications: _____
<b>8. If you've used a respirator, have you <u>ever had</u> any of the following problems? (If you've never used a respirator, check the following space and go to question 9: <input type="checkbox"/>)</b>		
<input type="checkbox"/>	<input type="checkbox"/>	<b>a) Eye irritation</b> If yes, have you successfully used a respirator since this happened? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<b>b) Skin allergies or rashes</b> If yes, have you successfully used a respirator since this happened? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<b>c) Anxiety</b> If yes, have you successfully used a respirator since this happened? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<b>d) General weakness or fatigue</b> If yes, have you successfully used a respirator since this happened? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<b>e) Any other problem that interferes with your use of a respirator</b> If yes, please describe: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?</b>



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). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>10. Have you <u>ever</u> lost vision in either eye (temporarily or permanently)?</b> If yes, when and what happened? _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>11. Do you <u>currently</u> have any of the following vision problems?</b>
<input type="checkbox"/>	<input type="checkbox"/>	a) Wear contact lenses
<input type="checkbox"/>	<input type="checkbox"/>	b) Wear glasses
<input type="checkbox"/>	<input type="checkbox"/>	c) Color blind
<input type="checkbox"/>	<input type="checkbox"/>	d) Any other eye or vision problem If yes, please describe: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>12. Have you <u>ever had</u> an injury to your ears, including a broken ear drum?</b> If yes, please describe: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>13. Do you <u>currently</u> have any of the following hearing problems?</b>
<input type="checkbox"/>	<input type="checkbox"/>	a) Difficulty hearing
<input type="checkbox"/>	<input type="checkbox"/>	b) Wear a hearing aid
<input type="checkbox"/>	<input type="checkbox"/>	c) Any other hearing or ear problem If yes, please describe: _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>14. Have you <u>ever</u> had a back injury?</b> If yes, when and what happened? _____ Do you have any current restrictions or limitations on your activities? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<b>15. Do you <u>currently</u> have any of the following musculoskeletal problems?</b>
<input type="checkbox"/>	<input type="checkbox"/>	a) Weakness in any of your arms, hands, legs, or feet
<input type="checkbox"/>	<input type="checkbox"/>	b) Back pain
<input type="checkbox"/>	<input type="checkbox"/>	c) Difficulty fully moving your arms and legs
<input type="checkbox"/>	<input type="checkbox"/>	d) Pain or stiffness when you lean forward or backward at the waist
<input type="checkbox"/>	<input type="checkbox"/>	e) Difficulty fully moving your head up or down
<input type="checkbox"/>	<input type="checkbox"/>	f) Difficulty fully moving your head side to side
<input type="checkbox"/>	<input type="checkbox"/>	g) Difficulty bending at your knees
<input type="checkbox"/>	<input type="checkbox"/>	h) Difficulty squatting to the ground
<input type="checkbox"/>	<input type="checkbox"/>	i) Climbing a flight of stairs or a ladder carrying more than 25 pounds (lbs)
<input type="checkbox"/>	<input type="checkbox"/>	j) Any other muscle or skeletal problem that interferes with using a respirator If yes to any of the above, please describe: _____

**Additional space for use by employees, if needed:**

***To be completed by staff:***

- Medically cleared for use of all respirators, including SCBA, subject to fit test.
- Medically cleared for use of all respirators, excluding SCBA, subject to fit test.
- Medically cleared for use of disposable and half-facepiece respirators, subject to fit test.
- Medically cleared for use of disposable respirators only, subject to fit test.
- Not medically cleared for use of respirators.
- Medical clearance is pending due to: \_\_\_\_\_  
\_\_\_\_\_

Health Professional Reviewer: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_





Date of exam: \_\_\_\_\_

**EMPLOYEE COPY OF RESPIRATOR MEDICAL RECOMMENDATIONS**

This form outlines the results of the OSHA Respirator Medical Evaluation. If you have any questions regarding this evaluation, please call Occupational Medicine at 952-883-6999.

Respirator Clearance Status:

- Medically cleared for use of all respirators, including SCBA, subject to fit test.
- Medically cleared for use of all respirators, excluding SCBA, subject to fit test.
- Medically cleared for use of disposable and half-facepiece respirators, subject to fit test.
- Not medically cleared for use of respirators.
- Medical clearance is pending due to: \_\_\_\_\_

Health Professional Reviewer: \_\_\_\_\_ Date: \_\_\_\_\_