

OSHA Respiratory Protection Medical Questionnaire Form

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 health care professional who will review it.

Company _____ Today's Date _____

Name _____ Social Security Number _____

Date of Birth _____ Sex (check one) Male Female

Your height _____ ft. _____ in. Your weight _____ lbs.

Your job title _____ Department _____ Shift _____

Your telephone number _____ Best time to phone you _____

Have you been told how to contact the health care professional who will review this questionnaire? Yes No

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)
- Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

Have you worn a respirator before? Yes No

If "yes," what type(s): _____

How often and under what conditions do you expect to wear a respirator?

- Escape only (no rescue)
- Emergency rescue only
- Less than 4 hours/week on average
- Less than 4 hours/day on average
- More than 4 hours/day on average

Describe the work effort you will be required to use while wearing a respirator:

- Light
- Moderate
- Heavy

Describe the work you will be doing while wearing a respirator:

Describe any other protective clothing or equipment you will be wearing when you wear a respirator:

Describe any special or hazardous conditions you might encounter while wearing a respirator (e.g., confined spaces, high test, high humidity, etc.)

If you know them, describe the possible chemicals, gases, dusts, or toxic substances you might be exposed to while wearing a respirator:

Do you currently smoke tobacco or have you smoked tobacco in the last month? Yes No

List any current medications you are taking _____

(over, please)

Additional Questions Required if Respirator Use Includes Full-Facepiece or Self-Contained Breathing Apparatus (SCBA)

SUPPLEMENT

Have you ever lost vision in either eye temporarily or permanently? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently have any of the following musculoskeletal problems? (ANSWER ALL)
Do you currently have any of the following vision problems?	Weakness in any of your arms, hands, legs, or feet <input type="checkbox"/> Yes <input type="checkbox"/> No
Wear contact lenses <input type="checkbox"/> Yes <input type="checkbox"/> No	Back pain <input type="checkbox"/> Yes <input type="checkbox"/> No
Color blind <input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty fully moving your arms and legs <input type="checkbox"/> Yes <input type="checkbox"/> No
Any other eye or vision problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty squatting to the ground <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had an injury to your ears, including a broken ear drum? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain or stiffness when you lean forward or backward at the waist <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently have any of the following hearing problems? (ANSWER ALL)	Difficulty fully moving your head up or down <input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty hearing <input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty fully moving your head side to side <input type="checkbox"/> Yes <input type="checkbox"/> No
Wear a hearing aid <input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty bending at your knees <input type="checkbox"/> Yes <input type="checkbox"/> No
Any other hearing or ear problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Climbing a flight of stairs or ladder carrying more than 25 lbs <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a back injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any other muscle or skeletal problem that interferes with using a respirator <input type="checkbox"/> Yes <input type="checkbox"/> No