Hartford HealthCare

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

To the employee: Can you read? (circle one): 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; only Health Care Professionals at the Colleague Health Services office will review it.

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).		
Name:	Date of Birth:	Age: yrs.
Height: ft. in.	Weight: lbs.	
Job Title:	Department:	
Phone Number:	Best time to call this number:	
Check the type of respirator you will use (you can check more than one category): a. ______ N, R, or P disposable respirator (filter-mask, non- cartridge type only) b. ______ Other type (e.g., half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus)		
Have you worn a respirator before (circle one): Yes No If 'yes' what type(s):		

1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month:	
☐ Yes - Number of years smoked: Amount you smoke:	
☐ No - Month/year you quit:	☐ Never smoked

	Yes	**No**	**Explanation**
2. Have you ever had any of the following conditions?			
Seizures (fits):			
Diabetes (sugar disease):			
Allergic reactions that interfere with your breathing:			
Claustrophobia (fear of closed-in places):			
Sleep Apnea/ Sleep Disorders:			
Unexplained Fatigue? Inappropriate inability to stay awake:			
Trouble smelling odors:			
3. Have you ever had any of the following pulmonary or lung problems?			
Asbestosis:			
Asthma:			
Chronic bronchitis:			
Emphysema:			
Pneumonia:			
Tuberculosis:			
Silicosis:			
Pneumothorax (collapsed lung):			
Lung cancer:			
Broken ribs:			
Any chest injuries or surgeries:			
Any other lung problem that you've been told about:			

Name:	DOB:

	Yes	No	Explanation
4. Do you currently have any of the following symptoms of pulmonary or lung illness?			
Shortness of breath:			
Shortness of breath when walking fast on level ground or walking up a slight hill or incline:			
Shortness of breath when walking with other people at an ordinary pace on level ground:			
Have to stop for breath when walking at your own pace on level ground:			
Shortness of breath when washing or dressing yourself:			
Shortness of breath that interferes with your job:			
Coughing that produces phlegm (thick sputum):			
Coughing that wakes you early in the morning:			
Coughing that occurs mostly when you are lying down:			
Coughing up blood in the last month:			
Wheezing:			
Wheezing that interferes with your job:			
Chest pain when you breathe deeply:			
Any other symptoms that you think may be related to lung problems:			
5. Have you ever had any of the following cardiovascular or heart problems?			
Heart attack:			
Stroke:			
Angina:			
Heart failure:			
Swelling in your legs or feet (not caused by walking):			
Heart arrhythmia (heart beating irregularly):			
High blood pressure:			
Any other heart problem that you've been told about:			
6. Have you ever had any of the following cardiovascular or heart symptoms?			
Frequent pain or tightness in your chest:			
Pain or tightness in your chest during physical activity:			
Pain or tightness in your chest that interferes with your job:			
In the past two years, have noticed your heart skipping or missing a beat:			
Heartburn or indigestion that is not related to eating:			
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?			
Breathing or lung problems:			
Heart trouble:			
Blood pressure:			
Seizures (fits):			
8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, go to question 9)			
Eye irritation:			
Skin allergies or rashes:			
Anxiety:			
General weakness or fatigue:			
Any other problem that interferes with your use of a respirator:			

Name:	DOB:

	Yes	No	Explanation
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?			
10. Have you ever lost vision in either eye (temporarily or permanently)?			
11. Do you currently have any of the following vision problems?			
Wear contact lenses:			
Wear glasses:			
Color blind:			
Any other eye or vision problem:			
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?			
Difficulty hearing:			
Wear a hearing aid:			
Any other hearing or ear problem:			
14. Have you ever had a back injury?			
15. Do you wear dentures?			
16. Do you currently have any of the following musculoskeletal problems?			
Weakness in any of your arms, hands, legs, or feet:			
Back pain:			
Difficulty fully moving your arms and legs:			
Pain or stiffness when you lean forward or backward at the waist:			
Difficulty fully moving your head up or down:			
Difficulty fully moving your head side to side:			
Difficulty bending at your knees:			
Difficulty squatting to the ground:			
Climbing a flight of stairs or a ladder carrying more than 25 lbs:			

Colleague Signature: ____ **Date:** _____________________

Completed by Fit Tester

Brand and Model Number	Size	Type	NIOSH Approval Number
☐ 3M 1860S	Small	N95	TC-84A-0006
☐ 3M 1860R	Regular	N95	TC-84A-0006
☐ 3M 8210	N/A	N95	TC-84A-0007
☐ Honeywell DC365	N/A	N95	TC-84A-9250
☐ Other (make/model/style/size):			
☐ **PASS** Qualitative (circle): Bittrex, Saccharin, Irritant Smoke			
☐ **PASS** Quantitative: PortaCount test			
☐ **FAIL** (reason):			

☐ I have instructed the colleague how to use the respirator listed above

Fit Tester Signature: ____ **Date:** _____________________