Intermountain® Employee Health

OSHA Respirator Employee Medical Evaluation Questionnaire

Mandatory - Appendix C to Sec. 1910.134

Name: _____ **Today's date:** _____ **Hospital/Facility Name:** _____ **EE#** _____

DOB: _____ Your age (to nearest year) _____ Sex: ☐ Male ☐ Female

Your height: _____ feet _____ inches Your weight: _____ pounds

Your job title: _____ Dept: _____

A phone number where you can be reached by the health care professional who reviews this questionnaire (include area code) _____

Check the type of respirator you have worn in the past (you can check more than one category, leave blank if unknown):

☐ N-95 : Make: _____ Model: _____ Size: _____

☐ PAPR: Hood Size: _____

☐ Other: _____

1. Do you currently or have you smoked tobacco during the previous month?
Yes ☐ No ☐ If yes:

a. At what age did you start smoking? _____
b. How long ago did you quit smoking? _____
c. How many packs per day did or do you smoke? _____

Yes	No	
		2. Have you ever had any of the following conditions?
☐	☐	a. Seizures (fits)
☐	☐	b. Diabetes (sugar disease)
☐	☐	c. Allergic reactions that interfere with your breathing
☐	☐	d. Claustrophobia (fear of closed-in places)
☐	☐	e. Trouble smelling odors
		3. Have you ever had any of the following pulmonary or lung problems?
☐	☐	a. Asbestosis
☐	☐	b. Asthma
☐	☐	c. Chronic bronchitis
☐	☐	d. Emphysema
☐	☐	e. Pneumonia
☐	☐	f. Tuberculosis
☐	☐	g. Silicosis
☐	☐	h. Pneumothorax (collapsed lung)
☐	☐	i. Lung cancer
☐	☐	j. Broken ribs
☐	☐	k. Any chest injuries or surgeries
☐	☐	l. Any other lung problem that you have been told about
		4. Have you ever had any of the following cardiovascular or heart problems?
☐	☐	a. Heart attack
☐	☐	b. Stroke
☐	☐	c. Angina
☐	☐	d. Heart failure
☐	☐	e. Swelling in your legs or feet (not caused by walking)
☐	☐	f. Heart arrhythmia (heart beating irregularly)
☐	☐	g. High blood pressure
☐	☐	h. Any other heart problem that you have been told about
		5. Have you ever had any of the following cardiovascular or heart symptoms?
☐	☐	a. Frequent pain or tightness in your chest
☐	☐	b. Pain or tightness in your chest during physical activity
☐	☐	c. Pain or tightness in your chest that interferes with your job
☐	☐	d. In the previous 2 years, have you noticed your heart skipping or missing a beat?
☐	☐	e. Heartburn or indigestion that is not related to eating
☐	☐	f. Any other symptoms that you think might be related to heart or circulation problems

Yes	No	
		6. Do you currently have any of the following symptoms of pulmonary or lung illness?
☐	☐	a. Shortness of breath
☐	☐	b. Shortness of breath when walking quickly on level ground or walking up a slight hill or incline
☐	☐	c. Shortness of breath when walking with other people at an ordinary pace on level ground
☐	☐	d. Have to stop for breath when walking at your own pace on level ground
☐	☐	e. Shortness of breath when washing or dressing yourself
☐	☐	f. Shortness of breath that interferes with your job
☐	☐	g. Coughing that produces phlegm (thick sputum)
☐	☐	h. Coughing that wakes you early in the morning
☐	☐	I. Coughing that occurs primarily when you are lying down
☐	☐	j. Coughing up blood in the last month
☐	☐	k. Wheezing
☐	☐	l. Wheezing that interferes with your job
☐	☐	m. Chest pain when you breathe deeply
☐	☐	n. Any other symptoms that you think might be related to lung problems
		7. Do you currently take medication for any of the following:
☐	☐	a. Breathing or lung problems
☐	☐	b. Heart trouble
☐	☐	c. Blood pressure
☐	☐	d. Seizures (fits)
		8. If you have 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
☐	☐	b. Skin allergies or rashes
☐	☐	c. Anxiety
☐	☐	d. General weakness and fatigue
☐	☐	e. Any other problems that interferes with your use of a respirator

9. Are you currently taking any medications? If yes, list.

_____

_____

_____

10. Has your employer told you how to contact the health care professional who will review this questionnaire: ☐ Yes ☐ No

11. Would you like to talk with the health-care professional who will review this questionnaire about your answers to this questionnaire?
☐ Yes ☐ No

Please explain any "yes" answers (use back of form if necessary)

_____

_____

Employee Signature: _____

Date: _____

Submit

****For Employee Health Nurse Use Only****

Notes: _____

_____

_____

EH Nurse Signature: _____ Date: _____

