THE DOCTORS TREATMENT CENTER

240 EAST STREET
PLAINVILLE, CT 06062
PH: 860-747-4541
FAX: 860-793-1218

7 MILL POND ROAD
GRANBY, CT 06035
PH: 860-653-2382
FAX: 860-653-6235

OSHA Respirator Evaluation Questionnaire (Mandatory)
CFR 1910.134 Appendix C

To the Employee:

Please complete the form below and submit it along with your completed confidential OSHA Respirator Medical Evaluation Questionnaire.

Employee Name: ______________________________

Address: ______________________________

____

Firehouse where employee will be working: ______________________________

Phone: (Home/Cell) ____________________ **(Work)** ____________________

Date of Birth: ____________________

Have you been seen at our office before? (Circle one) YES NO

Are you a structural firefighter? (Circle one) YES NO

If you are not a structural firefighter but are required to wear a respirator please indicate what type of respirator you are required to use?

____

Employee Signature: ______________________________ **Date:** ____________

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OSHA RESPIRATOR EVALUATION QUESTIONNAIRE

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 circle "YES" or "NO").

1. YES NO **Do you currently smoke tobacco, or have you smoked tobacco in the last 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

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 have been told about

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

YES NO a. Shortness of breath
YES NO b. Shortness of breath when walking 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 breath deeply

YES NO n. 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?

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
YES NO g. High blood pressure
YES NO h. Any other heart problem that you have been told about

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

YES NO a. Frequent pain or tghtness 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

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)

8. If you have used a respirator, have you ever had any of the following problems?
(If you have never used a respirator, check the following space _____ and go to question 9)

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 problems that interfere with your use of a respirator

9. YES NO **Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire?**

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. YES NO **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 blindness

YES NO d. Any other eye or vision problems

12. YES NO **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 problems

14. YES NO **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 or stiffness when you lean forward ot backwrad at the waist
YES NO e. Difficulty moving your head up or down
YES NO f. Difficulty moving your head 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

Employee Signature: ______________________________ **Date:** ______________________
Printed Name: ________________________________

FOR OFFICE USE BELOW

Check the one that applies:

☐ I have reviewed Part A Section 2 of this questionnaire with the employee and I do not recommend a physical examination be performed.

☐ I have reviewed Part A Section 2 of this questionnaire with the employee and I am recommending a physical examination be performed.

☐ I have reviewed Part A Section 2 of this questionnaire without the employee and I do not recommend a physical examination be performed.

☐ I have reviewed Part A Section 2 of this questionnaire without the employee and I am recommending a physical examination be performed.

____
Signature

____
Date