Reset Form

PSC | Federal Occupational Health
U.S. Department of Health and Human Services

Federal Occupational Health
FOH-22 OSHA Respirator Medical Evaluation Questionnaire
(Mandatory) Appendix C to Sec. 1910.134

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee: 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.

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). Today's date:_____

Name	Job Title	Height (self-report)
Age	Sex _____ (Select one)	Telephone (best time to call)	Weight (self-report)

Has your employer told you how to contact the health care professional who will review this questionnaire? (select one) Yes ☐ No ☐

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 ☐ half-face ☐ Supplied-air (Air-in-Line)
☐ full-face ☐ SCBA (Self-Contained Breathing Apparatus)
☐ PAPR (powered-air purifying)

Have you worn a respirator (select one)? Yes ☐ No ☐

If "Yes" what type(s):_____

To be completed by Clinic Staff - when indicated by Interagency Agreement ONLY:

_____ Height (ft/in) _____ Weight (lbs)
Measure without shoes **Verbal reporting is unacceptable**
Please record initial/secondary blood pressure and check one of the choices below:

Initial BP	_____	<140/<90 ____ Normal	>140/>90 ____ Elevated
Secondary BP	_____	<140/<90 ____ Normal	>140/>90 ____ Elevated

Instructions to examiner/clinician reviewing the questions on the following pages:
Since the answers to many of the questions can be subjective, talking to the client directly is the best way to determine the significance of these answers. When indicated, please ensure the follow-up questions are completed for conditions in which the client marks "YES".

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 select "Yes" or "No"). Any "Yes" answer should be explained. Include the following information: #1) is it a current or past problem. #2) approximately when did you have the problem (month/year), and #3) list current medication &/or treatment. Document this information in the margin next to the "Yes" answer.

1. Do you *currently* or have you ever smoked tobacco? Yes ☐ No ☐
   a. Have you smoked in the last month? Yes ☐ No ☐
2. Have you *ever had* any of the following conditions?
   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 Yes ☐ No ☐

Please use space below to document positive findings

For any positive response for items listed below, please provide requested info in space provided

Seizures:
1. Date of Last Seizure
2. More than one?
3. Type (Grand Mal, Petit Mal, Fever-related)
4. Current Meds to control?
5. Last time taken med?

Diabetes:
1. Last A1C level and date performed
2. Insulin Dependent?
3. Date of Last Hypoglycemic episode
4. Date of last ER or Urgent Care Visit?
5. Date of Last Hospitalization

Claustrophobia:
1. Ever interfere with use of respirator?
2. Longest time you ever wore a respirator (hh/mm))

3. Have you *ever had* any of the following pulmonary or lung problems?
   a. Asbestosis Yes ☐ No ☐
   b. Asthma Yes ☐ No ☐
   c. Broken Rib Yes ☐ No ☐
   d. Chronic bronchitis Yes ☐ No ☐
   e. Emphysema Yes ☐ No ☐
   f. Lung cancer Yes ☐ No ☐
   g. Pneumonia Yes ☐ No ☐
   h. Silicosis Yes ☐ No ☐
   i. Tuberculosis Yes ☐ No ☐
   j. Pneumothorax (collapsed lung) Yes ☐ No ☐
   k. Any chest injuries or surgeries Yes ☐ No ☐
   l. Any other lung problem that you've been told about Yes ☐ No ☐

Asthma:
1. Currently treated? With what meds:
2. Total lifetime ER visits or Hospitalizations
   # visits ___ Last visit ___ (year)
3. Frequency of attacks:
   #___/yr Last attack ___ (month/year)

Pneumothorax / Collapsed Lung:
1. Trauma / procedure related?
2. Spontaneous? If yes, date of last episode

4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath Yes ☐ No ☐
   b. Shortness of breath when walking fast 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 ☐

Shortness of breath:
1. How many steps can you climb without stopping for a breath?

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 breathe deeply Yes ☐ No ☐
n. Any other symptoms that you think may be related to lung problems Yes ☐ No ☐

For any positive response for items listed, please provide info in space provided

5. Have you *ever had* any of the following cardiovascular or heart problems?
   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 (heart beating irregularly) Yes ☐ No ☐
   g. High blood pressure Yes ☐ No ☐
   h. Any other heart problem that you've been told about Yes ☐ No ☐
6. Have you *ever head* any of the following cardiovascular or heart symptoms?
   a. Frequent pain or tightness 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 symptoms that are not related to eating Yes ☐ No ☐
   f. Any other symptoms that you think may be related to heart or circulation problems Yes ☐ No ☐
7. Do you *currently* take medication for any of the following problems?
   a. Breathing or lung problems Yes ☐ No ☐
   b. Heart trouble Yes ☐ No ☐
   c. Blood pressure Yes ☐ No ☐
   d. Seizures (fits) Yes ☐ No ☐
8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check the following box ☐ and go to Question 9)
   a. Eye irritation Yes ☐ No ☐
   b. Skin allergies or rashes Yes ☐ No ☐
   c. Anxiety Yes ☐ No ☐
   d. General weakness or fatigues Yes ☐ No ☐
   e. Any other problem that interferes with your use of a respirator Yes ☐ No ☐
9. Would you like to talk to the health care professiona will review this questionnaire about your answers? Yes ☐ No ☐

List all the medications you are taking for these conditions including when you started and when the last dosage was adjusted – attach page if needed:

These questions are SPECIFIC to using a respirator. If you have had any of these issues but they are NOT ASSOCIATED with respirator use, you should answer NO.

This means you WANT someone to speak to you, in person or on the telephone.

APPENDIX B

For any positive response for items listed, please provide info in space provided

Question 10 to 15 must be answered for full facepiece respirator or SCBA use

10.	Have you *ever lost* vision in either eye (temporarily or permanently)	Yes ☐ No ☐
11.	Do you *currently* have any of the following vision problems?	
a.	Wear contact lenses	Yes ☐ No ☐
b.	Wear glasses	Yes ☐ No ☐
c.	Color blind	Yes ☐ No ☐
d.	Any other eye or vision problem (describe)	Yes ☐ No ☐
12.	Have you *ever had* an injury to your ears, including a broken ear drum?	Yes ☐ No ☐
13.	Do you *currently* have any of the following hearing problems?	
a.	Difficulty hearing	Yes ☐ No ☐
b.	Wear a hearing aid	Yes ☐ No ☐
c.	Any other hearing or ear problem	Yes ☐ No ☐
14.	Have you *ever had* a back injury?	Yes ☐ No ☐
15.	Do you *currently* have any of the following musculoskeletal problems?	
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 or backward at the waist	Yes ☐ No ☐
e.	Difficulty fully moving your head up or down	Yes ☐ No ☐
f.	Difficulty fully 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.	Climbing a flight of stairs or a ladder carrying more than 25 lbs	Yes ☐ No ☐
j.	Any other muscle or skeletal problem <u>that interferes with using a respirator</u>	Yes ☐ No ☐
k.	In the last 3 months, have you been in the emergency room or hospital with pain?	Yes ☐ No ☐

Provide Date of Onset, current treatment (including meds), and known or presumed cause

Part B

Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes ☐ No ☐

   If ``yes,'' do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes ☐ No ☐

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes ☐ No ☐
   If ``yes,'' name the chemicals if you know them: _____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

Substance/Conditions		Description of exposure (if answer is yes)
a. Asbestos	Yes ☐ No ☐	
b. Silica (e.g., in sandblasting)	Yes ☐ No ☐	
c. Tungsten/cobalt (e.g., grinding or welding this material)	Yes ☐ No ☐	
d. Beryllium	Yes ☐ No ☐	
e. Aluminum	Yes ☐ No ☐	
f. Coal (for example, mining)	Yes ☐ No ☐	
g. Iron	Yes ☐ No ☐	
h. Tin	Yes ☐ No ☐	
i. Dusty environment	Yes ☐ No ☐	
j. Any other hazardous exposures	Yes ☐ No ☐	

4. List any second jobs or side businesses you have: _____
5. List your previous occupations: _____
6. List your current and previous hobbies: _____
7. Have you been in the military services? Yes ☐ No ☐
   If ``yes,'' were you exposed to biological or chemical agents (either in training or combat): Yes ☐ No ☐
8. Have you ever worked on a HAZMAT team? Yes ☐ No ☐
9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes ☐ No ☐
   If ``yes,'' name the medications if you know them: _____
   _____
10. Will you be using any of the following items with your respirator(s)?
    a. HEPA Filters: Yes ☐ No ☐
    b. Canisters (for example, gas masks): Yes ☐ No ☐
    c. Cartridges: Yes ☐ No ☐
11. How often are you expected to use the respirator(s)? (select ``yes'' or ``no'' for all answers that apply to you):
    a. Escape only (no rescue): Yes ☐ No ☐
    b. Emergency rescue only: Yes ☐ No ☐
    c. Less than 5 hours per week: Yes ☐ No ☐
    d. Less than 2 hours per day: Yes ☐ No ☐
    e. 2 to 4 hours per day: Yes ☐ No ☐
    f. Over 4 hours per day: Yes ☐ No ☐

12. During the period you are using the respirator(s), is your work effort

Light (less than 200 kcal per hour): Yes ☐ No ☐	If ``yes,'' how long does this period last during the average shift:_____hrs._____mins.
Examples of a light work effort are *sitting* while writing, typing, drafting, or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines.	
Moderate (200 to 350 kcal per hour): Yes ☐ No ☐	If ``yes,'' how long does this period last during the average shift:_____hrs._____mins.
Examples of moderate work effort are *sitting* while nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; *walking* on a level surface about 2 mph or down a 5- degree grade about 3 mph; or *pushing* a wheelbarrow with a *heavy* load (about 100 lbs.) on a level surface.	
Heavy (above 350 kcal per hour): Yes ☐ No ☐	If ``yes,'' how long does this period last during the average shift:_____hrs._____mins.
Examples of heavy work are *lifting* a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; *shoveling*; *standing* while bricklaying or chipping castings; *walking* up an 8- degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).	

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes ☐ No ☐
    If ``yes,'' describe this protective clothing and/or equipment: _____
14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes ☐ No ☐
15. Will you be working under humid conditions: Yes ☐ No ☐
16. Describe the work you'll be doing while you're using your respirator(s): _____
17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases): _____
18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of Toxic Substance	Estimated maximum exposure level per shift	Duration of exposure per shift

The name of any other toxic substances that you'll be exposed to while using your respirator: _____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (e.g., rescue, security, etc.): _____

To the best of my knowledge, the information I have provided is true and accurate.

_____ _____
Employee Name Date

_____
Employee Signature