

OSHA medical evaluation questionnaire for respirator use and instructions for filling it out

When OSHA requires a respirator, the employee must fill out a questionnaire as part of the medical evaluation.

**EMPLOYEE INSTRUCTIONS FOR FILLING OUT RESPIRATOR
MEDICAL EVALUATION QUESTIONNAIRE (MEQ)**

Attached is a medical evaluation questionnaire for you to fill out. The OSHA standard requires that any employee who wears a respirator must be medically evaluated to ensure the safety and health of the employee. Your answers to this questionnaire will be kept confidential. Your employer does not have the right to view your answers.

A physician or licensed health care professional (PLHCP) will review the questionnaire. If you have any questions about the questionnaire or concerns about respirator use and your health, you can call the PLHCP _____ at (_____) -- (_____)

<p>It is essential that you answer every question. If you need assistance, please contact the PLHCP listed above.</p>

If the PLHCP has any questions for you, s/he must be able to contact you. It is important that you include your home phone number and a time that you can be reached at home.

If you answer "yes" to any of the questions, please include any comments you might think important in helping the doctor evaluate your answers. (For example, if you have ever had pneumonia, note how long ago, or if you have high blood pressure, note if you are seeing a physician or taking medication to control it.) You can make notes near the question or on the back of the last page of this questionnaire.

The PLHCP may determine that a physical examination is necessary in order to better assess your ability to use a respirator. If so, your employer is required to provide you with a confidential medical examination at no cost to you.

The PLHCP will send a letter to you and your employer indicating if you are cleared for respirator use.

Thank you for your cooperation.

OSHA Respirator Medical Evaluation Questionnaire

To the employee: Can you read English (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, 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).

1. Today's date: _____

2. Last name: _____ First name: _____

3. Age (to nearest year): _____

4. Sex (circle one): Male Female

5. Height: _____ ft. _____ in.

6. Weight: _____ lbs.

7. Job title: _____

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

9. The best time to reach you at this number _____

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

11. Check the type of respirator you will use (you can check more than one category):

a. _____ Disposable respirator N, R, or P (filter-mask, non-cartridge type only).

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

12. Have you ever worn a respirator in the past: Yes No
If "yes," what type(s):

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. Do you currently smoke tobacco, or have you smoked tobacco in the last month: | Yes | No |
| 2. Have you ever had any of the following conditions? | | |
| a. Seizures: | Yes | No |
| b. Diabetes (sugar disease): | | |
| 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 |
| 3. Have you ever had any of the following pulmonary or lung problems? | | |
| 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've been told about: | Yes | No |
| 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 |
| 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 may be related to lung problems: | Yes | No |

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 had*** 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 indigestion that is 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: | 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 space 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 fatigue: | 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 professional who will review this questionnaire about your answers to this questionnaire:
- | | | |
|--|-----|----|
| | Yes | No |
|--|-----|----|

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

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|--|-----|----|
| 10. Have you <i>ever lost</i> vision in either eye (temporarily or permanently): | Yes | No |
| 11. Do you <i>currently</i> 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: | Yes | No |
| 12. Have you <i>ever had</i> an injury to your ears, including a broken eardrum: | 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 <i>ever had</i> a back injury: | Yes | No |
| 15. Do you <i>currently</i> 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 that interferes with using a respirator: | Yes | No |

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. Describe the work you'll be doing while you're using your respirator:

2. Will you be using any of the following items with your respirator?

- | | | |
|--|-----|----|
| a. HEPA Filters (pink, red): | Yes | No |
| b. Canisters (for example, gas masks): | Yes | No |
| c. Cartridges: | Yes | No |

3. How often are you expected to use the respirator (circle "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 <i>per week</i> : | Yes | No |
| d. Less than 2 hours <i>per day</i> : | Yes | No |
| e. 2 to 4 hours <i>per day</i> : | Yes | No |
| f. Over 4 hours <i>per day</i> : | Yes | No |

4. During the period you are using the respirator, is your work effort:

- | | | |
|---|-----|----|
| a. Light: [e.g., sitting while typing or writing; performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.] | Yes | No |
|---|-----|----|

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

- | | | |
|---|-----|----|
| b. Moderate: [e.g., sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, or assembling a moderate load (about 35 lbs.) at trunk level; walking; pushing a wheelbarrow with heavy load (about 100 lbs.) on a level surface.] | Yes | No |
|---|-----|----|

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

- | | | |
|---|-----|----|
| c. Heavy: [e.g., 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° grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).] | Yes | No |
|---|-----|----|

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

5. 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:

6. Describe any special or hazardous conditions you might encounter when you're using your respirator (e.g., confined spaces, life-threatening gases):

7. List the hazardous substances that you work with while wearing a respirator:

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

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

a. Asbestos:	Yes	No
b. Silica (e.g. in sandblasting):	Yes	No
c. Beryllium:	Yes	No
d. Tungsten/cobalt:	Yes	No
e. Aluminum:	Yes	No
f. Coal (for example, mining):	Yes	No
g. Iron:	Yes	No
h. Dusty environments:	Yes	No
i. Tin:	Yes	No
j. Solvents (e.g. paints, lacquers)	Yes	No
k. Any other hazardous exposures:	Yes	No

If "yes," describe these exposures:

10. At home have you been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or had skin contact with hazardous chemicals:
If "yes," name the chemicals if you know them:

11. List any second jobs or side businesses you have:

12. 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
13. Have you ever worked on a HAZMAT team?	Yes	No