U.S. DEPARTMENT OF COMMERCE
National Oceanic and Atmospheric Administration
(Rev10-08)

NOAA OSHA Respirator Medical Evaluation Questionnaire

Directions: OSHA requires every employee who has been selected to use any type of respirator to provide the information on pages one through three of this questionnaire. Please complete the form, sign and date it in the space provided on page three. When completing this form as part of a physical exam you should give the completed form to the medical provider performing the exam. The provider will determine if you are physically able to wear a respirator and complete page 4. If you already have a current physical exam on file, a NOAA health services officer can review that physical exam, determine if you are physically able to wear a respirator, and complete page 4. Please contact a NOAA health services officer if you have questions about this form or concerns regarding your physical ability to wear a respirator.

Section I. Employee Information:

1. LAST NAME, FIRST NAME, MIDDLE INITIAL:

2. Job Title:

Age Male ◯ Female ◯ Height (ft) (in) Weight (lbs)

Phone Number: Home: Work:

2. Have you worn a respirator: (Select One) **Yes** ◯ **NO** ◯

Name If ``yes,'' what type(s):

Section II. Relevant Medical History

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?

Seizures (fits)	**Yes** ◯ **NO** ◯
Diabetes (sugar disease)	**Yes** ◯ **NO** ◯
Allergic reactions that interfere with your breathing	**Yes** ◯ **NO** ◯
Claustrophobia (fear of closed-in places)	**Yes** ◯ **NO** ◯
Trouble smelling odors	**Yes** ◯ **NO** ◯

3. Have you ever had any of the following pulmonary or lung problems?

Asbestosis	**Yes** ◯ **NO** ◯
Asthma	**Yes** ◯ **NO** ◯
Chronic bronchitis	**Yes** ◯ **NO** ◯
Emphysema	**Yes** ◯ **NO** ◯
Pneumonia	**Yes** ◯ **NO** ◯
Tuberculosis	**Yes** ◯ **NO** ◯
Silicosis	**Yes** ◯ **NO** ◯
Pneumothorax (collapsed lung)	**Yes** ◯ **NO** ◯
Lung cancer	**Yes** ◯ **NO** ◯
Broken ribs	**Yes** ◯ **NO** ◯
Any chest injuries or surgeries	**Yes** ◯ **NO** ◯
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?

Shortness of breath	**Yes** ◯ **NO** ◯
Shortness of breath when walking fast on level ground or walking up a slight hill/incline	**Yes** ◯ **NO** ◯
Shortness of breath when walking with other people at an ordinary pace on level ground	**Yes** ◯ **NO** ◯
Have to stop for breath when walking at your own pace on level ground	**Yes** ◯ **NO** ◯
Shortness of breath when washing or dressing yourself	**Yes** ◯ **NO** ◯
Shortness of breath that interferes with your job	**Yes** ◯ **NO** ◯
Coughing that produces phlegm (thick sputum)	**Yes** ◯ **NO** ◯
Coughing that wakes you early in the morning	**Yes** ◯ **NO** ◯
Coughing that occurs mostly when you are lying down	**Yes** ◯ **NO** ◯
Coughing up blood in the last month	**Yes** ◯ **NO** ◯
Wheezing	**Yes** ◯ **NO** ◯

Wheezing that interferes with your job	Yes ◯ NO ◯
Chest pain when you breathe deeply	Yes ◯ NO ◯
Any other symptoms that you think may be related to lung's	Yes ◯ NO ◯

5. Have you ever had any of the following cardiovascular or heart problems?

Heart attack	Yes ◯ NO ◯
Stroke	Yes ◯ NO ◯
Angina	Yes ◯ NO ◯
Heart Failure	Yes ◯ NO ◯
Swelling in your legs or feet (not caused by walking)	Yes ◯ NO ◯
Heart arrhythmia (heart beating irregularly)	Yes ◯ NO ◯
High blood pressure	Yes ◯ NO ◯
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?

Frequent pain or tightness in your chest	Yes ◯ NO ◯
Pain or tightness in your chest during physical activity	Yes ◯ NO ◯
Pain or tightness in your chest that interferes with your job	Yes ◯ NO ◯
In the past two years, have you noticed your heart skipping or missing a beat	Yes ◯ NO ◯
Heartburn or symptoms that is not related to eating	Yes ◯ NO ◯
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?

Breathing or lung problems	Yes ◯ NO ◯
Heart trouble	Yes ◯ NO ◯
Blood Pressure	Yes ◯ NO ◯
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 space and go to question 9) Yes ◯ NO ◯

Eye irritation	Yes ◯ NO ◯
Skin allergies or rashes	Yes ◯ NO ◯
Anxiety	Yes ◯ NO ◯
General weakness or fatigue	Yes ◯ NO ◯
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 your responses to this questionnaire? Yes ◯ NO ◯

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?

Wear glasses	Yes ◯ NO ◯
Wear contact lenses	Yes ◯ NO ◯
Color blind	Yes ◯ NO ◯
Any other eye or vision problem	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?

Difficulty hearing	**Yes** ◯ **NO** ◯
Wear a hearing aid	**Yes** ◯ **NO** ◯
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?

Weakness in any of your arms, hands, legs, or feet	**Yes** ◯ **NO** ◯
Back pain	**Yes** ◯ **NO** ◯
Difficulty fully moving your arms and legs	**Yes** ◯ **NO** ◯
Pain or stiffness when you lean forward or backward at the waist	**Yes** ◯ **NO** ◯
Difficulty fully moving your head up or down	**Yes** ◯ **NO** ◯
Difficulty fully moving your head side to side	**Yes** ◯ **NO** ◯
Difficulty bending at your knees	**Yes** ◯ **NO** ◯
Difficulty squatting to the ground	**Yes** ◯ **NO** ◯
Climbing a flight of stairs or a ladder carrying more than 25 lbs	**Yes** ◯ **NO** ◯
Any other muscle or skeletal problem that interferes with using a respirator	**Yes** ◯ **NO** ◯

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

Employee Name **Date**

_____

Employee Signature

TO BE COMPLETED BY THE EXAMINER/REVIEWER:

Respirator Clearance

This employee has been found to be physically able to use the following (check each [ ] that applies):

- ☐ Single use, filter mask (four attachment points)
- ☐ Half-faced cartridge-type, negative pressure
- ☐ Full-faced cartridge-type respirator, negative pressure
- ☐ Half-faced powered cartridge-type (PAPR)
- ☐ Full-faced powered cartridge-type (PAPR)
- ☐ Self-contained breathing apparatus (SCBA)
- ☐ Hood/helmet powered cartridge-type (PAPR)
- ☐ Half-faced/Full-faced/Hood/Helmet (NOT positive pressure)

When wearing a respirator, the employee has been informed to limit activity level to the following (check one [ ]):

- ☐ Mild Exertion
- ☐ Moderate Exertion
- ☐ Heavy Exertion (No specified limitations)

Other limitations needed (if any) when wearing a respirator:

Circle one: (if not marked clearance expires in 1 year.)

This respirator clearance expires **1 ◯ 2 ◯ 3 ◯** years from the date below.

☐ ***The mandatory questionnaire has been reviewed, and the employee IS physically able to use a respirator.***

☐ ***This employee has been found to be physically NOT able to use a respirator***

☐ ***There is insufficient information to make a determination at this time***

The following additional tests, or medical information, will be required in order to make a determination regarding the safe use of a respirator by this employee.

Medical Provider's Name (Print) **Medical Provider's Signature** **Date:**

Place of Employ ment Phone Number: