**OSHA Medical Questionnaire**

**PART 1. PERSONAL INFORMATION**

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| Date: \_\_\_\_\_\_\_\_\_\_ | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(first) (middle) (last)* |  SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Age: \_\_\_\_\_ | Sex (circle one): Male Female | Height: \_\_\_\_ ft. \_\_\_\_\_in. | Weight: \_\_\_\_\_ lbs. |
| Job Title:  | Department:  |
| A phone number where you can be reached by the healthcare professional who reviews this questionnaire: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ The best time to phone you at this number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No |
| Type of respirator(s) you will be using (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have you worn a respirator in the past? (circle one): Yes/NoIf "yes," what type(s):  |

**PART 2. HEALTH QUESTIONS**

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| 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" to the following. |

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 (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

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) not associated with a cold: 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 you think 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 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

e. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check here ❒ 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 healthcare professional who will review this questionnaire about your answers to this questionnaire? Yes/No