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

Medical Providers Name: **Date**

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Medical Providers Signature