California State University
Northridge

Environmental Health & Safety

OSHA Respirator Medical Evaluation Questionnaire

Form SF 2004.01

To The Employer: Answers to the questions in Section 1, and to question 9 in Section 2, do not require a medical examination.

To The Employee: Can you read? 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.

SECTION 1. (Mandatory). The following information must be provided by every employee who has been selected to use any type of respirator.

Today's date: _____
Your name: _____
Your age: _____ (to nearest year)
Sex: Male Female
Your height: _____ft. _____in.
Your weight: _____lbs.
Your job title: _____
A phone number (including area code) where you can be reached by the health care 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?
Yes ☐ No ☐

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

☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).

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

Have you ever worn a respirator? Yes ☐ No ☐

If yes, what type(s):_____

SECTION 2. (Mandatory for Questions 1-9). Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. (Check 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 (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 problems 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 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 problems 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 (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.) Never Used ☐

   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** regulator or a self-contained breathing apparatus **(SCBA)**. For employees who have been selected to use other types of respirators, answering these questions is voluntary.

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 Yes ☐ No ☐

12. Have you *ever had* an injury to your ears, including a broken eardrum? Yes ☐ No ☐

    Do you *currently* have any of the following problems?

    a. Difficulty hearing Yes ☐ No ☐
    b. Wear a hearing aid Yes ☐ No ☐
    c. Any other hearing or ear problem Yes ☐ No ☐

13. Have you *ever had* a back injury? Yes ☐ No ☐

    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 that interferes with using a respirator Yes ☐ No ☐

Signature: _____ Date: _____

Print Name: _____