GUNDERSEN HEALTH SYSTEM®

Occupational Health Services
OSHA Respirator Medical Evaluation Periodic Questionnaire Update

Section I (Mandatory)

1. Name (Please Print)_____
2. Date_____
3. Your age_____ Date of Birth_____
4. Sex (check one) ☐ Male ☐ Female
5. Your height_____ft. _____ in. Your weight _____ lbs.
   Change in weight by 20 pounds or more (in the last year)? ☐ Yes ☐ No
6. Your job title_____
7. A phone number where you can be reached between the hours of 8:00 a.m. and 5:00 p.m. by the health care professional who reviews this questionnaire _____
8. The best time to phone you at this number_____
9. Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No
   The health care professional at Gundersen can be reached at Occupational Health Services, Ellen Gordon, RN, COHN-S at (608) 775-5416 or Mark Heffernan, RN at (608) 775-8654.
10. Have you worn a respirator? If yes, what type_____
11. Check the type of respirator you will use if you know.
    ☐ N, R, or P disposable respirator (filter - mask, non-cartridge type only, N95)
    ☐ Other type (for example: half mask, full-facepiece type, powered air purifying, supplied air (PAPR), self-contained breathing apparatus.
12. In the past year, how many times have you worn your respirator?_____

Please check Yes or **No to each question**

1. **In the past year**, have you had any problems when wearing a respirator?

Eye irritation	☐ Yes ☐ No
Skin allergies or rashes	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No
General weakness or fatigue	☐ Yes ☐ No
Any other problems that interferes with your use of a respirator?	☐ Yes ☐ No

If yes, please explain:_____

2. **In the past year**, has there been a change in the workplace conditions which may result in a substantial increase in the physiological burden that respirator use places on you? ☐ Yes ☐ No

If yes, please explain:_____

3. Do you currently smoke tobacco or have you smoked in the last month? ☐ Yes ☐ No
If yes, how many years have you smoked?_____ How many packs/day?_____

4. **In the past year,** have you had any of the following:

Chest pain with exertion?	☐ Yes ☐ No
Newly diagnosed cardiac (heart) disease?	☐ Yes ☐ No
Heart attack?	☐ Yes ☐ No
Problems breathing or shortness of breath?	☐ Yes ☐ No
Wheezing/whistling in the chest?	☐ Yes ☐ No
Asthma attacks?	☐ Yes ☐ No
Diagnosis of emphysema, chronic bronchitis or other lung disease	☐ Yes ☐ No
New onset of uncontrolled diabetes?	☐ Yes ☐ No
New onset of uncontrolled blood pressure?	☐ Yes ☐ No
Seizures?	☐ Yes ☐ No
Passing out spells?	☐ Yes ☐ No
Problems from previously diagnosed heart or lung diseases?	☐ Yes ☐ No
Stroke?	☐ Yes ☐ No
Claustrophobia (fear of closed-in places)	☐ Yes ☐ No

If answered yes to any of the above, please explain:_____

5. 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 ☐ Yes ☐ No

6. Would you like to talk to the health care professional who will review this questionnaire about your answers? ☐ Yes ☐ No

Name_____ Signature_____ Date_____
(Please Print)

Reviewed by: _____ Date_____

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Section II

Questions 7 through 14 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.

7. **In the past year**, have you experienced any problems with your eyes? ☐ Yes ☐ No
   If yes, please explain:_____

8. Do you wear contact lenses? ☐ Yes ☐ No

9. Do you wear glasses? ☐ Yes ☐ No

10. **In the past year**, have you had any problems with your ears/hearing? ☐ Yes ☐ No
    If yes, Please explain:_____

11. **In the past year**, have you had a back injury or developed a sore back? ☐ Yes ☐ No
    If yes, please explain:_____

12. **In the past year**, have you developed any of the following musculoskeletal problems; weakness in your arms or legs, difficulty moving your arms or legs, pain or stiffness when leaning forward or backward, difficulty moving your head up/down or side to side, difficulty bending knees, or squatting to the ground? If yes, please explain: ☐ Yes ☐ No
    _____
    _____
    _____
    _____

13. **In the past year**, have you had any difficulty or been given restrictions not to carry over 25 pounds? ☐ Yes ☐ No
    If yes, please explain:_____

14. **In the past year**, have you developed any type of musculoskeletal problems not mentioned above? ☐ Yes ☐ No
    If yes, please explain:_____

Name_____ Signature_____ Date_____
(Please Print)