City of Virginia Beach

**Volunteer Home Address If Not On Record in OSHS**

Occupational Safety and Health Services
2424 Courthouse Drive
Building-18 Suite 183
Phone: 757.385.4851
FAX: 757.385.5621

# RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

**BEFORE WEARING A RESPIRATOR (INCLUDING N/P/R - 95/99/100) EMPLOYEES MUST BE MEDICALLY EVALUATED IN COMPLIANCE WITH OSHA 29CFR 1910.134 STANDARD ONLY**

**INSTRUCTIONS: Your supervisor must allow you to answer this questionnaire during normal working hours at a time and place that is convenient to you. To maintain your confidentiality, your supervisor must not look at or review your answers. Please deliver the completed form to OSHS or send to PPE@vbgov.com where it will be reviewed by a health care professional and kept in your confidential work medical record.**

**The following information must be provided by every employee who is required to use any type of respirator**

| Employee Name (Last, First MI) | Job Title | Date of Birth | Today's Date |
|---|---|---|---|
| | | | |

| Last 5 of SSN: / Emp. ID or VOL if a volunteer: | E-Mail Address | Height Ft. In. | Weight Lbs. | Gender (M/F/) |
|---|---|---|---|---|
| | | | | |

| Phone # where you can be reached & best time to contact you at this number: | Supervisor's Name and E-mail Address: |
|---|---|
| | |

**Check the type of respirator you will use:**

| | | | | |
|---|---|---|---|---|
| Supplied-air Respirator (SAR)/Airline Respirator ☐<br>Self-Contained Breathing Apparatus (SCBA) ☐ | Full Face with Cartridges ☑<br>Half Face with Cartridges ☑ | Filtering Facepiece Mask Select all that apply: | | |
| Have you worn a respirator? ☐ Y ☐ N<br>If yes, what type(s): | Powered Air Purifying Respirator (PAPR) with Cartridges ☐ | N ▬ | P ▬ | R ☐ |
| Filter/Cartridge type:▬ HEPA (pink) ☐ Organic Vapor (black) ☐ Multi-Gas/Vapor (Olive Green) ☐ CBRN Canister ☐ Combination/Stacked (check all that apply) or Describe: | | 95 ▬ | 99 ☐ | 100 ▬ |

## MEDICAL HISTORY – EMPLOYEE MUST COMPLETES THIS SECTION

**☐ Y ☐ N Do you currently smoke, or have you smoked in the last month?**

**☐ Y ☐ N Have you ever had any of the following conditions? If no, check no and go to the next question.**

☐ Y ☐ N Seizures (fits)
☐ Y ☐ N Diabetes (sugar disease)
☐ Y ☐ N Allergic reaction effecting your breathing
☐ Y ☐ N Claustrophobia (fear of closed-in spaces)
☐ Y ☐ N Trouble smelling odors

**☐ Y ☐ N Have you ever had any of the following lung or pulmonary problems? If no, check no and go to the next question.**

☐ Y ☐ N Asbestosis
☐ Y ☐ N Asthma
☐ Y ☐ N Chronic bronchitis
☐ Y ☐ N Emphysema
☐ Y ☐ N Pneumonia
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Silicosis
☐ Y ☐ N Pneumothorax (collapsed lung)
☐ Y ☐ N Lung cancer
☐ Y ☐ N Broken ribs
☐ Y ☐ N Any chest injuries or surgeries
☐ Y ☐ N Any other lung problems you've been told about

**☐ Y ☐ N Do you currently take medication for any of the following? If no, check no and go to the next question.**

☐ Y ☐ N Breathing or lung problems
☐ Y ☐ N Heart trouble
☐ Y ☐ N Blood pressure
☐ Y ☐ N Seizures
☐ Y ☐ N Other, list medication(s):

**☐ Y ☐ N Do you currently have any of the following symptoms of pulmonary or lung illness? If no, check no and go to the next question.**

☐ Y ☐ N Shortness of breath
☐ Y ☐ N Shortness of breath when walking fast on level ground or walking up a slight hill or incline
☐ Y ☐ N Shortness of breath when walking with other people at an ordinary pace on level ground
☐ Y ☐ N Have to stop for breath when walking at your own pace on level ground
☐ Y ☐ N Shortness of breath when washing or dressing yourself
☐ Y ☐ N Shortness of breath that interferes with your job
☐ Y ☐ N Coughing that produces phlegm (thick sputum)
☐ Y ☐ N Coughing that wakes you early in the morning
☐ Y ☐ N Coughing that occurs mostly when you are lying down
☐ Y ☐ N Coughing up blood in the last month
☐ Y ☐ N Wheezing
☐ Y ☐ N Wheezing that interferes with your job
☐ Y ☐ N Chest pain when you breathe deeply
☐ Y ☐ N Any other problems that you think may be related to lung problems

**☐ Y ☐ N Have you ever had any of the following heart or cardiovascular problems? If no, check no and go to the next question.**

☐ Y ☐ N Heart attack
☐ Y ☐ N Stroke
☐ Y ☐ N Angina
☐ Y ☐ N Heart failure
☐ Y ☐ N Swelling of the legs or feet (not caused by walking)
☐ Y ☐ N Heart arrhythmia (heart beating irregularly)

**☐ Y ☐ N Have you ever had any of the following heart or cardiovascular symptoms? If no, check no and go to the next question.**

☐ Y ☐ N Frequent pain or tightness in your chest
☐ Y ☐ N Pain or tightness in your chest during physical activity
☐ Y ☐ N Pain or tightness in your chest that interferes with your job
☐ Y ☐ N In the last two years, have you noticed your heart skipping or missing a beat
☐ Y ☐ N Heartburn or indigestion that is not related to eating
☐ Y ☐ N Any other symptoms that you think may be related to heart or circulation problems
☐ Y ☐ N High blood pressure
☐ Y ☐ N Any other heart problems that you've been told about

**☐ Y ☐ N If you've used a respirator, have you ever had any of the following problems?**

☐ Y ☐ N Eye irritation
☐ Y ☐ N Skin allergies or rashes
☐ Y ☐ N Anxiety
☐ Y ☐ N General weakness or fatigue
☐ Y ☐ N Any other problems that interfere with your use of a respirator

**☐ Y ☐ N Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?**

**MEDICAL HISTORY – THESE QUESTIONS MUST BE ANSWERED BY EVERY EMPLOYEE WHO HAS BEEN SELECTED TO USE EITHER A FULL-FACEPICE RESPIRATOR OR A SELF-CONTAINED BREATHING APPARATUS (SCBA). FOR EMPLOYEES WHO HAVE BEEN SELECTED TO USE OTHER TYPES OF RESPIRATORS, ANWERING THESE QUESTIONS IS VOLUNTARY**

☐ Y ☐ N Have you ever lost your vision in either eye (temporarily or permanently)?

☐ Y ☐ N Have you ever had an injury to your ears, including a broken eardrum?

☐ Y ☐ N Have you ever had a back injury?

**☐ Y ☐ N Do you currently have any of the following vision problems? If no, check no and go to the next question.**

☐ Y ☐ N Wear contact lenses
☐ Y ☐ N Wear glasses
☐ Y ☐ N Color blind
☐ Y ☐ N Any other eye or vision problems

**☐ Y ☐ N Do you currently have any of the following hearing problems? If no, check no and go to the next question.**

☐ Y ☐ N Difficulty hearing
☐ Y ☐ N Wear a hearing aid
☐ Y ☐ N Any other hearing or ear problems

**☐ Y ☐ N Do you currently have any of the following musculoskeletal problems.**

☐ Y ☐ N Weakness in any of your arms, hands, legs, or feet
☐ Y ☐ N Back pain
☐ Y ☐ N Difficulty fully moving your arms or legs
☐ Y ☐ N Pain and stiffness when you lean forward or backward at the waist
☐ Y ☐ N Difficulty fully moving your head up or down
☐ Y ☐ N Difficulty fully moving your head side to side
☐ Y ☐ N Difficulty bending at your knees
☐ Y ☐ N Difficulty squatting to the ground
☐ Y ☐ N Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.
☐ Y ☐ N Any other muscle or skeletal problem(s) that interferes with using a respirator

**THESE ADDITIONAL QUESTIONS MAY BE ASKED BY THE HEALTHCARE PROVIDER TO DETERMINE ADDITIONAL EXPOSURE FACTORS**

☐ Y ■ N Do you work in a place that has lower than normal amounts of oxygen (over 5,000 ft, confined space, etc.)?

☐ Y ☐ N If yes, do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when working under these conditions?

☐ Y ☐ N At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals, (e.g. gases, fumes, or dust), or have you come into skin contact with hazardous chemicals? If yes, name the chemical(s):_____

**☐ Y ☐ N Have you ever worked with any of these materials, or under any of the conditions listed below?**

☐ Y ☐ N Asbestos
☐ Y ☐ N Silica (sandblasting)
☐ Y ☐ N Dusty Environment
☐ Y ☐ N Tungsten/cobalt (welding, grinding)
☐ Y ☐ N Aluminum
☐ Y ☐ N Iron
☐ Y ☐ N Tin
☐ Y ☐ N Any other hazardous exposure, please describe:

■ Y ☐ N Will you be working in hot conditions (77 degrees F or above)?

■ Y ☐ N Will you be working in humid conditions?

■ Y ☐ N Will you be wearing protective clothing and/or equipment (other than a respirator) when you are using your respirator?

If yes, please describe the protective clothing or equipment: PPE such as Gown/Tyvek Suit, Medical Gloves

Please describe the work you will be doing when you are using your respirator: EMS response, patient care and transport

**How often are you expected to wear the respirator?**

☐ Y ■ N Escape only (no rescue)
■ Y ☐ N Emergency rescue only
☐ Y ■ N Less than 5 hrs. per week
☐ Y ■ N Less than 2 hrs. per day
■ Y ☐ N 2-4 hrs. per day
☐ Y ■ N Over 4 hrs. per day

**List any second jobs/side businesses, previous occupation, hobbies, etc. when you worked with/around hazardous material:**_____

**During the work period when you are using your respirator is your work effort:**

☐ Y ■ N Light (sitting while writing/typing, light assembly work, standing while operating a drill press, etc.).
If yes, how long does this work last during your work shift: Shift:_____Hours:_____Minutes:_____

■ Y ☐ N Moderate (sitting while nailing or filing, driving a truck or bus in urban traffic, standing while drilling or nailing, transferring moderate loads (about 35 lbs., performing assembly work, pushing a wheelbarrow);
If yes, how long does this work last during your work shift: Shift: 2 Hours:_____Minutes:_____

■ Y ☐ N Heavy (lifting/moving/climbing with a heavy load (about 40 lbs.) from floor to waits/shoulder level, shoveling, walking on a graded surface, shoveling, standing while brick laying/casting, working on a loading dock, etc.)
If yes, how long does this work last during your work shift: Shift: 2 Hours:_____Minutes:_____

**Describe the work you will perform and describe any special hazards or conditions you might encounter when using a respirator (confined space, hazardous gases, etc.):** COVID-19 exposure and similar airborne hazards

**Provide any know information about toxic substances you may be exposed to when using your respirator:**

Name of toxic substance(s): Virus or other pathogens

Estimated maximum exposure level per shift: 12 hrs

Duration of exposure per shift: 2-4 hrs

**Describe any special responsibilities you will have while using your respirator that may affect the safety and well-being of others (rescue, security, etc.):** EMS - Rescue

**MEDICAL CLEARANCE - PHYSICIAN OR OTHER LICENSED HEALTH CARE PROFESSIONAL (PLHCP) (MD, DO, NP, PA, RN) MUST COMPLETE THIS SECTION**

Medical Clearance for use of identified respirator(s):

☐ Approved ☐ Approved with Restrictions ☐ Denied

Remarks:

Clinician Printed Name and Signature: Date: