

Palomar Health OSHA Respirator Medical Evaluation Questionnaire

To the PLHCP:

Answers to questions in Section 1, and to question 6 in Section 2 do not require a medical examination. Employees must be provided with a confidential means of contacting the health care professional who will review this questionnaire.

To the Employee: Can you read and understand this questionnaire? Yes No

Your employer must allow you to answer the 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:

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

Today's Date: _____

Employee Name: _____

Job Title: _____

Date of Birth: _____

Sex: Male Female

Height: _____ ft. _____ in.

Weight (lbs.): _____

Phone Number: _____

Best Time to Call: _____

1. Has your employer told you how to contact the healthcare professional who will review this questionnaire?
 Yes No
2. Check the type of respirator(s) you currently/will use.
 N, R, or P disposable respirator (filter-mask, non-cartridge type only).
 Other type (Ex, half- or full-facepiece type, PAPR, supplied-air, SCBA).
Fill in type here: _____
3. Have you worn a respirator?
 Yes No If "Yes," what type? _____

Section 2:

Questions 1 through 6 below must be answered by every employee who has been selected to use any type of respirator (please select "yes" or "no").

1. Have you ever had any of the following conditions?
 Yes No a. Allergic reactions that interfere with your breathing:
If "yes", what did you react to? _____
 Yes No b. Claustrophobia (fear of closed-in places)

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2. Do you currently have any of the following symptoms of pulmonary or lung illness?
- Yes No a. Shortness of breath when walking fast on level ground or walking up a slight hill or incline.
 - Yes No b. Have to stop for breath when walking at your own pace on level ground.
 - Yes No c. Shortness of breath that interferes with your job.
 - Yes No d. Wheezing that interferes with your job.
 - Yes No e. Any other symptoms that you think may be related to lung problems.
 - Yes No f. Coughing that produces phlegm (thick sputum).
 - Yes No g. Coughing up blood in the last month.
 - Yes No h. Chest pain when you breath deeply.
3. Do you currently have any of the following cardiovascular or heart symptoms?
- Yes No 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. Any other symptoms that you think may be related to heart or circulation problems.
4. Do you currently take medication for any of the following problems?
- Yes No a. Breathing or lung problems
 - Yes No b. Heart trouble
 - Yes No c. Nose, throat or sinuses
 - Yes No d. Are your problems under control with these medications?
- If you've never used a respirator, check the box and go to question 6.**
5. If you've ever used a respirator, have you ever had any of the following problems while respirator is being used?
- Yes No a. Skin allergies or rashes
 - Yes No b. Anxiety
 - Yes No c. General weakness or fatigue
 - Yes No d. Any other problem that interferes with your use of a respirator?
6. Would you like to talk to the healthcare professional who will review this questionnaire?
- Yes No

Employee Signature: _____

Date: _____

PLHCP (CHS Clinician Signature): _____

Date: _____