Form F: Email completed Form F to Straub: Jennifer.oldershaw@straub.net and dora.sakata@straub.net

Straub Occupational Health Services
800 South King Street • Honolulu, Hawaii 96813 • Phone No. (808) 529-4949 • Fax No. (808) 529-4950

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

To the employee: Can you read? ☐ Yes ☐ No

Part A. Section 1 Please print legibly.

Legal Name		Age	☐ Male ☐ Female	Company Name
Social Security # XXX-XX-	Date of Birth			
Job Title	Department	A phone number where you can be reached by the health care professional who reviews this questionnaire (include area code): _____ The best time to call you at this number: _____		

Has your employer told you how to contact the healthcare 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 worn a respirator? ☐ Yes ☐ No If "Yes", what type(s):

Part A. Section 2. Please 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 problem 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 breath .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 problem that you've been told about	☐ Yes	☐ No
6) Have you ever had any of the following cardiovascular 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) Seizure	☐ 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) ____		
a) Eye irritation	☐ Yes	☐ No
b) Skin allergies or rashes	☐ Yes	☐ No
c) Anxiety	☐ Yes	☐ No
d) General weakness or fatigues	☐ 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

Medications (if none, write none) _____

_____

Allergies (If none, write none) _____

Employee's Signature:	Date:

OFFICE USE ONLY

EXAMINATION

Height		
Weight		
Blood Pressure		
Pulse		
Distance unc/corr	20/	
Near unc/corr	20/	
	Normal	**Abnormal**
Olfactory test		
Whisper test		
Facial configuration		
Heart		
Chest and lungs		
Tympanic membranes	☐ R ☐ L	☐ R ☐ L

Additional Options (M.D. discretion)

☐ **Full audiogram**

Audiograms								
	250	500	1000	2000	3000	4000	6000	8000
R								
L								

☐ **Electrocardiogram**

☐ **Treadmill stress test**

☐ **Chest X-ray (one view)**

Comments

_____

_____

_____

_____

_____ _____

Examiner's Signature Date