MEDCARE OCCUPATIONAL HEALTH

31047 State Highway 100 · Los Fresnos, TX 78566
+1 956-233-2103 · medcareocc@gmail.com

PATIENT ID / RECORD # _____

OSHA Respirator Medical Evaluation · Part A

FORM MC-105

TO THE EMPLOYER Answers to questions in Section 1, and question 9 in Section 2 of Part A, do not require a medical examination.

TO THE EMPLOYEE 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.

PART A · SECTION 1 — MANDATORY FOR EVERY EMPLOYEE SELECTED TO USE A RESPIRATOR

FIRST NAME _____ LAST NAME _____ SSN / EMPLOYEE ID _____

DATE OF BIRTH _____ AGE _____ SEX ☐ Male ☐ Female TODAY'S DATE _____

HEIGHT (FT / IN) _____ WEIGHT (LB) _____ CELL / HOME PHONE _____ BEST TIME TO REACH YOU _____

COMPANY _____ LOCATION / JOB # _____ YOUR JOB TITLE _____

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):*

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

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

Have you ever worn a respirator? ☐ YES ☐ NO

If "YES", What type(s): _____

Have you ever <u>failed</u> a respirator examination or pulmonary function test? ☐ YES ☐ NO

If "YES", Why? _____

Have you ever been <u>denied</u> or <u>turned down</u> for the use of a respirator? ☐ YES ☐ NO

If "YES", Why? _____

PART A · SECTION 2 — MANDATORY

Questions 1 through 9 must be answered by every employee who has been selected to use any type of respirator.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? ☐ YES ☐ NO

If "YES", How long have you been smoking? _____ *Amount per day?* _____

What type of tobacco? (Check all that apply) ☐ Cigarettes ☐ Cigars ☐ Pipe tobacco

If "NO", Are you a former smoker? ☐ YES ☐ NO

How long ago did you quit? _____ *How long did you smoke?* _____ *Amount per day?* _____

2. Have you ever had any of the following conditions?

Explain all "yes" answers in the space provided (Include dates and treatment)

A.	Seizures	☐ 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?

Explain all "yes" answers in the space provided (Include dates and treatment)

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	

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FIRST NAME	LAST NAME	DATE OF BIRTH	TODAY'S DATE

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

Explain all "yes" answers in the space provided (Include dates and treatment)

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 you think may be related to lung problems	☐ YES ☐ NO	

5. Have you ever had any of the following cardiovascular or heart problems?

Explain all "yes" answers in the space provided (Include dates and treatment)

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 or heart symptoms?

Explain all "yes" answers in the space provided (Include dates and treatment)

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 2 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 you think may be related to heart or circulation problems	☐ YES ☐ NO	

7. Do you currently take medication for any of the following problems?

Explain all "yes" answers in the space provided (List medications and dosages)

A.	Breathing or lung problems	☐ YES ☐ NO	
B.	Heart trouble	☐ YES ☐ NO	
C.	Blood pressure	☐ YES ☐ NO	
D.	Seizures	☐ YES ☐ NO	

8. If you have used a respirator, have you ever had any of the following problems?

Explain all "yes" answers in the space provided

☐ Check if you have never used a respirator, then skip to question 9

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 your answers on this questionnaire? ☐ YES ☐ NO

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OSHA Respirator Medical Evaluation · Questions 10–15

FORM MC-105

FIRST NAME	LAST NAME	DATE OF BIRTH	TODAY'S DATE

MANDATORY for every employee selected to use a full-facepiece respirator or a self-contained breathing apparatus (SCBA).

VOLUNTARY for employees selected to use other types of respirators — answering questions 10–15 is optional.

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?**		
	Explain all "yes" answers in the space provided (Include dates and treatment)		
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	
13.	**Do you currently have any of the following hearing problems?**		
	Explain all "yes" answers in the space provided (Include dates and treatment)		
A.	Difficulty hearing	☐ YES ☐ NO	
B.	Wear a hearing aid	☐ YES ☐ NO	
C.	Any other hearing or ear problem	☐ YES ☐ NO	
14.	**Have you ever had a back injury?**	☐ YES ☐ NO	
15.	**Do you currently have any of the following musculoskeletal problems?**		
	Explain all "yes" answers in the space provided (Include dates and treatment)		
A.	Weakness in any part 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	

PART B · DISCRETIONARY QUESTIONS

Any of these questions, and others not listed, may be added at the discretion of the reviewing health care professional.

1.	**In your present job, are you working at high altitudes (over 5,000 ft) or in a place that has lower than normal amounts of oxygen?**	☐ YES ☐ NO	
	If "YES", do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions?	☐ YES ☐ NO	
2.	**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?**	☐ YES ☐ NO	
	If "YES", Name the chemicals if you know them: _____		
3.	**Have you ever worked with any of the materials, or under any of the conditions listed below?**		
	If "YES", Describe these exposures (Include dates and treatment)		
A.	Asbestos	☐ YES ☐ NO	
B.	Silica (e.g., in sandblasting)	☐ YES ☐ NO	
C.	Tungsten/Cobalt (e.g., grinding or welding this material)	☐ YES ☐ NO	
D.	Beryllium	☐ YES ☐ NO	
E.	Aluminum	☐ YES ☐ NO	
F.	Coal (e.g., mining)	☐ YES ☐ NO	
G.	Iron	☐ YES ☐ NO	
H.	Tin	☐ YES ☐ NO	
I.	Dusty environments	☐ YES ☐ NO	
J.	Any other hazardous exposures	☐ YES ☐ NO	
4.	**List any previous occupations:** _____		
5.	**List your current and previous hobbies:** _____		
6.	**List any second jobs or side businesses you have:** _____		

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7. **Have you been in the military services?** ☐ YES ☐ NO
If "YES", were you exposed to biological or chemical agents (either in training or combat)? ☐ YES ☐ NO
List the chemicals (if known): _____

8. **Have you ever worked on a HAZMAT team?** ☐ YES ☐ NO
If "YES", please list: _____

9. **Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason?** *(Including over-the-counter medications)* ☐ YES ☐ NO
If "YES", Name the medications (if known): _____

10. **Will you be using any of the following items with your respirator(s)?**
- **A.** HEPA Filters ☐ YES ☐ NO
- **B.** Canisters (e.g., gas masks) ☐ YES ☐ NO
- **C.** Cartridges ☐ YES ☐ NO

11. **How often are you expected to use the respirator(s)?**
- **A.** Escape only (No Rescue) ☐ YES ☐ NO
- **B.** Emergency Rescue only ☐ YES ☐ NO
- **C.** Less than 5 hours per week ☐ YES ☐ NO
- **D.** Less than 2 hours per day ☐ YES ☐ NO
- **E.** 2 to 4 hours per day ☐ YES ☐ NO
- **F.** Over 4 hours per day ☐ YES ☐ NO

12. **During the period you are using the respirator(s), is your work effort:**
- **A.** Light (less than 200 kcal per hour) ☐ YES ☐ NO
  If "YES", how long does this period last during the average shift: _____ hours _____ minutes
  ** Examples of light work effort: sitting while writing, typing, drafting, or performing light assembly work; standing while operating a drill press (1–3 lbs.) or controlling machines.*
- **B.** Moderate (200 to 350 kcal per hour) ☐ YES ☐ NO
  If "YES", how long does this period last during the average shift: _____ hours _____ minutes
  ** Examples of moderate work effort: sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.*
- **C.** Heavy (above 350 kcal per hour) ☐ YES ☐ NO
  If "YES", how long does this period last during the average shift: _____ hours _____ minutes
  ** Examples of heavy work effort: lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).*

13. **Will you be wearing protective clothing/equipment (other than the respirator) when you are using your respirator?** ☐ YES ☐ NO
If "YES", please describe this protective clothing and/or equipment: _____

14. **Will you be working under hot conditions?** *(Temperatures exceeding 77° Fahrenheit)* ☐ YES ☐ NO

15. **Will you be working under humid conditions?** ☐ YES ☐ NO

16. **Describe the work you will be doing while you are using your respirator(s):**

_____

_____

17. **Describe any special or hazardous conditions you might encounter when you are using your respirator(s)?**
(e.g., confined spaces, life-threatening gases):

_____

18. **Provide the following information** *(if known)* **for each toxic substance that you will be exposed to when you are using your respirator(s):**

A. 1st toxic substance *(name):* _____
Estimated max exposure level per shift: _____ Duration of exposure per shift: _____

B. 2nd toxic substance *(name):* _____
Estimated max exposure level per shift: _____ Duration of exposure per shift: _____

C. 3rd toxic substance *(name):* _____
Estimated max exposure level per shift: _____ Duration of exposure per shift: _____

D. List any other toxic substances that you will be exposed to while using your respirator: _____

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

_____

EMPLOYEE SIGNATURE _____ DATE _____