

# Medical Assessment

## Questionnaire



**Workplace  
Wellbeing**

### Part 1: Employer Information

Supervisor Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Department: \_\_\_\_\_ Address: \_\_\_\_\_

### Part 2: Employee Information

Name: \_\_\_\_\_ Occupation/Title: \_\_\_\_\_ Employee No.: \_\_\_\_\_  
E-mail: \_\_\_\_\_ Phone No.: \_\_\_\_\_ Date of request: \_\_\_\_\_

### Part 3: Conditions of Respirator Use

#### Activities requiring respirator use:

Frequency of use:       Daily       Weekly       Monthly.       Yearly       Other  
Duration of use (per shift):     <15 min.     >15 min.     >2 hours     Variable     Other  
Exertion level during use:     Light       Moderate     Heavy       Other:  
Expected temperature during use:     <0 °C       >0 and <25 °C       >25 °C  
Atmospheric pressure during use:     Reduced     Normal/Ambient     Increased

#### Uncontrolled hostile environment:

Emergency escape.     Firefighting.       Police activity.       Rescue operations  
 IDLH       Hazardous materials       Oxygen deficiency     Confined spaces  
Other explain: \_\_\_\_\_

#### Other PPE

Specify additional types of PPE required:

Estimated total weight of tools/equipment carried during respirator use:



519.850.4000  
800.815.9980



3330 Dingman Drive  
London, Ontario, N6E 3W8



info@osg.ca  
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**Part 4: Types of Respirators Used**

- Tight-fitting
- Non-tight fitting
- SCBA – open circuit
- Mouth bit
- SCBA – Closed circuit
- Air-purifying, non-powered
- Airline, continuous-flow
- SCBA - escape
- Air-purifying, powered
- Airline, pressure-demand
- SCBA – closed-circuit escape
- Multi-functional pressure-demand/Airline with escape
- Supplied-air suit
- Combined airline with air-purifying elements
- Other: \_\_\_\_\_



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**Part 5: Respirator User's Health Conditions**

Underlying medical conditions can have adverse effects while using a respirator. Please indicate if you have experienced or have any of the following health conditions.

**Yes**, I have experienced or have at least one of the listed health conditions.

**No**, I have not experienced any of the listed health conditions.

Shortness of breath

Heart problems

Dizziness/nausea

Fainting spells

Unusual facial features

Breathing difficulties

Hypertension

Seizures

Asthma

Chronic bronchitis

Cardiovascular disease

Temperature susceptibility

Emphysema

Thyroid problems

Claustrophobia/Fear of heights

Lung disease

Diabetes

Hearing impairment

Chest pain on exertion

Neuromuscular disease

Pacemaker

Unusual skin conditions

Vision impairment

Dentures

Reduced sense of smell

Panic attacks

Reduced sense of taste

Color blindness

Back/neck problems

Allergies

Other conditions affecting respirator use:

Prescription medication to control a condition:

Have you had previous difficulty while using a respirator?  Yes  No

Are you concerned with your ability to properly and safely use a respirator?  Yes  No

If you answered "Yes" to any of the questions asked in Part 6, an assessment by a health care professional is required prior to respirator use.

Signature of respirator user: \_\_\_\_\_ Signature of supervisor: \_\_\_\_\_ Date: \_\_\_\_\_



**Part 6: Health Care Professional Assessment (if required)**

Date of assessment: \_\_\_\_\_

Respirator use permitted:  Yes  No  Uncertain

Referred to medical assessment:  Yes  No

Comments:

Reassessment date: \_\_\_\_\_

**Part 7: Medical Assessment (if required)**

Date of assessment: \_\_\_\_\_

Class 1. No restrictions

Class 2. Some specific restrictions apply, specify: \_\_\_\_\_

Class 3. Respirator use NOT permitted

Name of Physician: \_\_\_\_\_ Signature of Physician: \_\_\_\_\_

