OSHA Respirator Medical Evaluation Questionnaire

Appendix C to Sec. 1910.134:

COMPANY NAME:_____ **Phone #**_____

To the employer: Answers to questions in Section 1 and to question 9 in section 2 of Part A do not require a medical examination

To the employee: Can you read? Yes No If No who assisted with questionnaire _____

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

Your Name _____ Today's Date:_____
Sex (circle one): Male or Female Your Age _____ Height _____ Weight _____
Your Job Title _____
Phone Number including area code _____-_____-_____ Best Time To Call:_____
Has your employer told you how to contact the health care professional who will review this questionnaire? (Circle One) Yes No
Check the type of respirator you will use. You can check more that one category ☐ N, R, or P disposable respirator (filter – mask, non-cartridge type only) ☐ Other type (for example half or full face type, powered-air purifying, supplied air) ☐ SCBA Have you worn a respirator? Yes No If yes, what types?_____

PART A. Section 2. Mandatory – Must be answered by any employee selected to use a respirator

ANSWER THE FOLLOWING QUESTIONS (Questions 1-9)	**YES**	**NO**
Do you **currently** smoke tobacco or have you smoked in the **last month**?		
If yes. Number of years _____ Number of cigarettes per day _____		
Have you **EVER** had any of the following conditions?		
Seizures (fits)		
Diabetes (sugar disease)		
Allergic Reactions that interfere with your breathing		
Claustrophobia (Fear of Closed in Spaces)		
Trouble Smelling Odors		
Have you **EVER** had any of the following pulmonary or lung problems?		
Asbestosis		
Asthma:		
If yes. Do you take medications for it currently		
Chronic Bronchitis		
Emphysema		
Pneumonia - If yes: How old were you?_____		
Tuberculosis		
Silicosis		
Pneumothorax (Collapsed Lung) If yes: When _____		
Lung Cancer		
Broken Ribs If yes: When _____		

	YES	NO
Chest injuries or surgeries		
Any other lung problems that you have been told about?		
Do you **CURRENTLY** have any of the following symptoms of lung illness?		
Shortness of breath		
Shortness of breath when walking fast on level ground?		
Shortness of breath when walking up a slight hill or incline?		
Do you have to stop for breath when walking at your own pace on level ground?		
Shortness of breath when washing or dressing yourself?		
Shortness of breath that interferes with your job?		
Coughing that produces phlegm (thick sputum)		
Coughing that occurs mostly when you are lying down?		
Coughing up blood in the last month?		
Wheezing?		
Wheezing that interferes with your job		
Chest pain when you breathe deeply?		
Any other symptoms that you think may be related to lung problems?		
Have you **EVER HAD** any of the following heart problems?		
Heart Attack - If yes, what year _____		
Stroke		
Angina (Chest Pain)		
Heart Failure (Fluid in the lungs)		
Swelling in your legs or feet **not** caused by walking?		
Heart arrhythmia – heart beating irregularly? If yes, what year _____		
High Blood Pressure If yes, are you taking medication: Yes No		
Any other heart problem you've been told about?		
Have you **EVER HAD** any of the following heart symptoms?		
Frequent pain or tightness in your chest? If yes, when _____		
Pain or tightness in your chest during physical activity? If yes , when _____		
Pain or tightness in your chest that interferes with your job?		
In the past two years have you noticed your heart skipping a beat?		
Heartburn or indigestion that is **NOT related** to eating?		
Any other symptoms that you think may be related to the heart or circulatory problems		
Do you **CURRENTLY** take medication for any of the following problems?		
Breathing or lung problems		
Heart Trouble		
Blood Pressure		
Seizures (Fits)		
If you've used a respirator, have you **EVER HAD** any of the following problems? If you've never used a respirator check here _____.		
Eye Irritation		
Skin Allergies or Rashes		
Anxiety		
General Weakness or fatigue		
Any other problem that interferes with your use of a respirator		
Would you like to talk to the doctor who will review this questionnaire? If yes, how can she reach you?_____ What specific questions do you have – write them below?		
CONTINUE ON TO THE NEXT PAGE ONLY IF USING A FULL FACE OR SCBA		

ANSWER IF USING A FULL FACE PIECE RESPIRATOR OR SCBA Employees who use other types of respirators may answer voluntarily.		
	YES	**NO**
Have you **EVER** lost vision in either eye (temp. or permanently)?		
Do you **CURRENTLY** have any of the following vision problems?		
Wear Contact Lenses		
Wear Glasses		
Color Blind		
Any other eye or vision problems?		
Have you **EVER HAD** an injury to your ears, including broken ear drum?		
Have you **CURRENTLY** have any of the following hearing problems?		
Difficulty hearing		
Wear a hearing aid		
Any other hearing or ear problems		
Have you **EVER HAD** a back injury?		
Do you **CURRENTLY** have any of the following musculoskeletal problems		
Weakness in your arms, hands, legs or feet?		
Back Pain		
Difficulty moving your arms and legs		
Pain or stiffness when you lean forward or backward at the waist		
Difficulty fully moving your head up or down		
Difficulty moving your head side to side		
Difficulty bending at your knees		
Difficulty squatting to the ground		
Difficulty climbing a flight of stairs or a ladder carrying >25 lbs.		
Do you have any other muscle or skeletal problem that interferes with using a respirator?		

PART B: ADDITIONAL QUESTIONS

	YES	**NO**
Are you working at high altitudes (over 5000 feet) or in areas with lower than normal amounts of oxygen?		
If yes, do you have feelings of dizziness, shortness of breath, pounding in your chest or any other symptoms?		
At home or work have you been exposed to hazardous solvents or airborne chemicals or have you come into skin contact with hazardous chemicals? If yes: Describe _____		
Have you worked on a HAZMAT team?		
Have you been in the military service?		
If yes, were you exposed to biological or chemical agents?		
List your current or previous hobbies that exposed you to hazardous materials.		
List any second jobs or businesses that you may have had exposure in the past.		
Have you been exposed to any of the following in the past?		
Asbestos		
Silica (Sandblasting)		
Tungsten/Cobalt (Grinding or welding Materials)		
Beryllium		
Aluminum		
Coal or Iron or Tin If yes, circle the one		
Any other hazardous exposures? If yes, list.		