OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

(Appendix C to Sec. 1910.134, Last revised 08/07/12)

To the Employer: Answers to questions in Section 1, and to question 9 in Section 2, 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): The following information must be provided by every employee who has been selected to use any type of respirator. Please print legibly.

1. Today's date (MM/DD/YY):_____
2. Your name:_____
3. Your age (to nearest year):_____
4. Sex: ❑ Male ❑ Female
5. Height: _____ft. _____in. / Weight: _____lbs.
6. Your job title:_____
7. A 10-digit phone number where you can be reached by a healthcare professional about this questionnaire:_____
8. The best time to phone you at this number:_____
9. Has your employer told you how to contact the healthcare professional who will review this questionnaire? ..... ❑ Yes ❑ No
10. Check the type of respirator you will use (mark all that apply):
    a. ❑ N, R, or P disposable respirator (ex. filter-mask, non-cartridge type only)
    b. ❑ Other type (ex. half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)
11. Have you worn a respirator? ..... ❑ Yes ❑ No
    a. If Yes, what type(s):_____

Part A. Section 2. (Mandatory): Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. Please select ONE answer for each question (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 ..... ❑ 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 breathe 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 or heart 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. Seizures ❑ Yes ❑ No
8. If you've used a respirator before, have you *ever had* any of the following problems?
   ↳ *If you've never used a respirator, mark the checkbox to the right and proceed to question 9* ❑ N/A
   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 answers to this questionnaire? ❑ Yes ❑ No

Date:_____ Employee's Signature:_____

***** Please return the completed questionnaire to Employee Health Services. *****

THIS SECTION TO BE COMPLETED BY AN AUTHORIZED REPRESENTATIVE IN EMPLOYEE HEALTH ONLY

Select ONE: ❑ Proceed to Fit Testing ❑ Sent to healthcare provider for further review

Date:_____ Reviewed by (Name):_____ Signature:_____