OCCUPATIONAL MEDICAL SERVICES

Your Partner in Employee Health

OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

Appendix C to Sec. 1910.134

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator.

To Employee: Can you read? ❑ Yes ❑ No ~ CLEARLY PRINT ALL RESPONSES. Your employer must allow you to answer questionnaire during normal working hrs, or at a convenient time & place. To maintain confidentiality, your employer must not look at/ review your answers, & your employer must tell you how to deliver/send this questionnaire to the health care professional for review.

To Employer: Answering questions Sect 1, and to question 9 in Sect 2 of Pt A, do not require exam.

Full Name: _____ Today's Date: _____

Home Phone: _____ Cell Phone: _____

DOB & Age: _____ Soc Sec No: _____

Height/Weight: _____ ft. _____ in. / _____ lbs. Sex: ❑ Male ❑ Female

Company: _____ Job Title: _____

10. ❑ Yes ❑ No ~ Has your employer told you how to contact the health care professional who will review this questionnaire?

11. Check the type of respirator you will use (check all that may apply):
    a. _____ N, R, or P disposable respirator (filter-mask, non- cartridge type only).
    b. _____ Other type (ex, ½ or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. ❑ Yes ❑ No ~ Have you worn a respirator? If "Yes", what type(s)?: _____

Part A. Section 2. (Mandatory) Questions 1 - 9 below must be answered by every employee who has been selected to use any type of respirator.

1. ❑ Yes ❑ No ~ Do you **currently** smoke tobacco, or smoked tobacco in the last month?

2. Have you **ever had** any of the following conditions?
    a. ❑ Yes ❑ No ~ Seizures (fits)
    b. ❑ Yes ❑ No ~ Diabetes (sugar disease)
    c. ❑ Yes ❑ No ~ Allergic reactions that interfere with your breathing
    d. ❑ Yes ❑ No ~ Claustrophobia (fear of closed-in places)
    e. ❑ Yes ❑ No ~ Trouble smelling odors

3. Have you **ever had** any of the following pulmonary or lung problems?

❑ Yes ❑ No ~ Asbestosis
❑ Yes ❑ No ~ Asthma
❑ Yes ❑ No ~ Chronic Bronchitis
❑ Yes ❑ No ~ Emphysema
❑ Yes ❑ No ~ Pneumonia
❑ Yes ❑ No ~ Tuberculosis
❑ Yes ❑ No ~ Pneumothorax/collapsed lung
❑ Yes ❑ No ~ Lung cancer
❑ Yes ❑ No ~ Broken ribs
❑ Yes ❑ No ~ Any chest injuries/surgeries
❑ Yes ❑ No ~ Other lung problem you've been told about
❑ Yes ❑ No ~ Silicosis

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4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?
   - ❑ Yes ❑ No ~ Wheezing
   - ❑ Yes ❑ No ~ Shortness of breath
   - ❑ Yes ❑ No ~ Chest pain (breathing deep)
   - ❑ Yes ❑ No ~ Coughing that produces phlegm
   - ❑ Yes ❑ No ~ Shortness of breath when washing or dressing
   - ❑ Yes ❑ No ~ Coughing that occurs mostly when lying down
   - ❑ Yes ❑ No ~ Any other symptoms that you think may be related to lung problems
   - ❑ Yes ❑ No ~ Have to stop for breath when walking at your own pace on level ground
   - ❑ Yes ❑ No ~ Shortness of breath when walking fast on level ground/walking up slight hill/incline
   - ❑ Yes ❑ No ~ Shortness of breath when walking with other people at ordinary pace on level ground
   - ❑ Yes ❑ No ~ Coughing up blood in the last month
   - ❑ Yes ❑ No ~ Wheezing that interferes with your job
   - ❑ Yes ❑ No ~ Coughing that wakes you early in the morning
   - ❑ Yes ❑ No ~ Shortness of breath interfering with job
5. Have you **ever had** any of the following cardiovascular or heart problems?
   - ❑ Yes ❑ No ~ Heart Attack
   - ❑ Yes ❑ No ~ Stroke
   - ❑ Yes ❑ No ~ Angina
   - ❑ Yes ❑ No ~ Heart Failure
   - ❑ Yes ❑ No ~ Swelling in legs/feet (not from walking)
   - ❑ Yes ❑ No ~ Heart arrhythmia (irregular heart beat)
   - ❑ Yes ❑ No ~ High blood pressure
   - ❑ Yes ❑ No ~ Other heart problem you've been told about?
6. Have you **ever had** any of the following cardiovascular or heart symptoms?
   - ❑ Yes ❑ No ~ Frequent pain or tightness in your chest
   - ❑ Yes ❑ No ~ Pain or tightness in your chest during physical activity
   - ❑ Yes ❑ No ~ Pain or tightness in your chest that interferes with your job
   - ❑ Yes ❑ No ~ In the past two years, have you noticed your heart skipping or missing a beat
   - ❑ Yes ❑ No ~ Heartburn or indigestion that is not related to eating
   - ❑ Yes ❑ No ~ Any other symptoms that you think may be related to heart or circulation problems
7. Do you **currently** take medication for any of the following problems?
   - ❑ Yes ❑ No ~ Breathing or lung problems
   - ❑ Yes ❑ No ~ Heart trouble
   - ❑ Yes ❑ No ~ Blood pressure
   - ❑ Yes ❑ No ~ Seizures (fits)
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)
   - ❑ Yes ❑ No ~ Eye irritation
   - ❑ Yes ❑ No ~ Anxiety
   - ❑ Yes ❑ No ~ Skin allergies or rashes
   - ❑ Yes ❑ No ~ Any other problem that interferes with your use of respirator
   - ❑ Yes ❑ No ~ Generally weak/fatigued
9. ❑ Yes ❑ No ~ Would you like to discuss your answers with the health care provider reviewing them?

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. ❑ Yes ❑ No ~ Have you **ever lost** vision in either eye (temporarily or permanently)?
11. Do you **currently** have any of the following vision problems?
    - ❑ Yes ❑ No ~ Wear contact lenses
    - ❑ Yes ❑ No ~ Color blind
    - ❑ Yes ❑ No ~ Wear glasses
    - ❑ Yes ❑ No ~ Any other eye or vision problem
12. ❑ Yes ❑ No ~ Have you **ever had** an injury to your ears, including a broken ear drum?

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13. Do you **currently** have any of the following hearing problems? ❑ Yes ❑ No ~ Difficulty hearing
❑ Yes ❑ No ~ Other hearing/ear problem ❑ Yes ❑ No ~ Wear hearing aid

14. ❑ Yes ❑ No ~ Have you **ever had** a back injury?

15. Do you **currently** have any of the following musculoskeletal problems?
❑ Yes ❑ No ~ Back pain ❑ Yes ❑ No ~ Difficulty bending at your knees
❑ Yes ❑ No ~ Difficulty fully moving arms/legs ❑ Yes ❑ No ~ Difficulty fully moving head up/down
❑ Yes ❑ No ~ Difficulty squatting to the ground ❑ Yes ❑ No ~ Difficulty fully moving head side-side
❑ Yes ❑ No ~ Pain or stiffness when you lean forward or backward at the waist
❑ Yes ❑ No ~ Climbing a flight of stairs or a ladder carrying more than 25 lbs
❑ Yes ❑ No ~ Any other muscle or skeletal problem that interferes with using a respirator
❑ Yes ❑ No ~ Weakness in any of your arms, hands, legs, or feet

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Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. ❑ Yes ❑ No ~ In your present job, are you working at high altitudes (over 5,000 feet) 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?

2. ❑ Yes ❑ No ~ At work or home, have you ever been exposed to hazardous solvents, airborne chemicals (e.g., gases, fumes, or dust), or have come into skin contact with hazardous chemicals? 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?
❑ Yes ❑ No ~ Asbestos ❑ Yes ❑ No ~ Silica (**e.g.**, in sandblasting)
❑ Yes ❑ No ~ Beryllium: Yes/No ❑ Yes ❑ No ~ Aluminum
❑ Yes ❑ No ~ Coal (for example, mining) ❑ Yes ❑ No ~ Iron
❑ Yes ❑ No ~ Tin ❑ Yes ❑ No ~ Dusty environments
❑ Yes ❑ No ~ Tungsten/cobalt (e.g., grinding or welding this material)
❑ Yes ❑ No ~ Any other hazardous exposures
If "yes," describe these exposures:_____

4. List any second jobs or side businesses you have:_____

5. List your previous occupations:_____

6. List your current and previous hobbies:_____

7. ❑ Yes ❑ No ~ Have you been in the military services?
❑ Yes ❑ No ~ If "yes," were you exposed to biological or chemical agents (in training or combat)?

8. ❑ Yes ❑ No ~ Have you ever worked on a HAZMAT team?

9. ❑ Yes ❑ No ~ 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)If "yes," name the medications:_____

10. Will you be using any of the following items with your respirator(s)?
❑ Yes ❑ No ~ HEPA Filters ❑ Yes ❑ No ~ Canisters (ex. Gas Masks) ❑ Yes ❑ No ~ Cartridges

11. How often are you expected to use the respirator(s)? (select all that apply)

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❑ Yes ❑ No ~ Escape only (no rescue) ❑ Yes ❑ No ~ Emergency rescue only
❑ Yes ❑ No ~ Less than 5 hrs **per week** ❑ Yes ❑ No ~ Less than 2 hrs **per day**
❑ Yes ❑ No ~ 2 to 4 hrs per day ❑ Yes ❑ No ~ Over 4 hrs per day

12. During the period you are using the respirator(s), is your work effort:
    a. ❑ Yes ❑ No ~ **Light** (less than 200 kcal per hour) If "yes," how long does this period last during the average shift? _____hrs._____mins. Examples of a light work effort are **sitting** while writing, typing, drafting, performing light assembly work; **standing** while operating a drill press (1-3 lbs.) controlling machines.
    b. ❑ Yes ❑ No ~ **Moderate** (200 to 350 kcal per hour) If "yes," how long does this period last during the average shift:_____hrs._____mins. Examples of moderate work effort are **sitting** while nailing or filing; **driving** a truck or bus in urban traffic; **standing** while drilling, nailing, performing assembly work, 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; **pushing** a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.
    c. ❑ Yes ❑ No ~ **Heavy** (above 350 kcal per hour)If "yes," how long does this period last during the average shift:_____hrs._____mins. Examples of heavy work are **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. ❑ Yes ❑ No ~ Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator? If "yes," describe this protective clothing and/or equipment:

14. ❑ Yes ❑ No ~ Will you be working under hot conditions (temperature exceeding 77 deg. F)?

15. ❑ Yes ❑ No ~ Will you be working under humid conditions?

16. Describe the work you'll be doing while you're using your respirator_____

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):_____

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the Toxic Substance	Estimated Max Exposure Level Per Shift	Duration of Exposure Per Shift

The name of any other toxic substances that you'll be exposed to while using your respirator:

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):

_____

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