

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:	<input type="checkbox"/> Male <input type="checkbox"/> 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):

- _____ N, R, or P disposable respirator (filter-mask, non- cartridge type only).
- _____ Other type (ex, 1/2 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?

- Yes No ~ Seizures (fits)
- Yes No ~ Diabetes (sugar disease)
- Yes No ~ Allergic reactions that interfere with your breathing
- Yes No ~ Claustrophobia (fear of closed-in places)
- Yes No ~ Trouble smelling odors

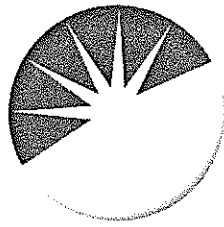
3. Have you **ever had** any of the following pulmonary or lung problems?

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Asbestosis | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Pneumothorax/collapsed lung |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Lung cancer |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Chronic Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Broken ribs |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Any chest injuries/surgeries |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Other lung problem you've been told about |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Silicosis |

Arbutus: (443) 524-2737 ~ Belcamp: (410) 272-7756

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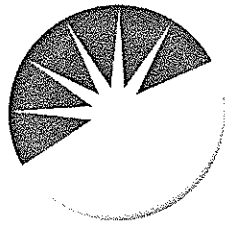
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4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?
- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Wheezing | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Coughing up blood in the last month |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Shortness of breath | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Wheezing that interferes with your job |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Chest pain (breathing deep) | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Coughing that wakes you early in the morning |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Coughing that produces phlegm | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Shortness of breath interfering with job |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Shortness of breath when washing or dressing | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Coughing that occurs mostly when lying down | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Any other symptoms that you think may be related to lung problems | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Have to stop for breath when walking at your own pace on level ground | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Shortness of breath when walking fast on level ground/walking up slight hill/incline | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Shortness of breath when walking with other people at ordinary pace on level ground | |
5. Have you **ever had** any of the following cardiovascular or heart problems?
- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Swelling in legs/feet (not from walking) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Heart arrhythmia (irregular heart beat) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ High blood pressure |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Heart Failure | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Other heart problem you've been told about? |
6. Have you **ever had** any of the following cardiovascular or heart symptoms?
- | |
|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Frequent pain or tightness in your chest |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Pain or tightness in your chest during physical activity |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Pain or tightness in your chest that interferes with your job |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ In the past two years, have you noticed your heart skipping or missing a beat |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Heartburn or indigestion that is not related to eating |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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?
- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Breathing or lung problems | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Blood pressure |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Heart trouble | <input type="checkbox"/> Yes <input type="checkbox"/> 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)
- | | | |
|---|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Eye irritation | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Skin allergies or rashes | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Generally weak/fatigued |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Any other problem that interferes with your use of respirator | |
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?
- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Wear contact lenses | <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Wear glasses |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ~ Color blind | <input type="checkbox"/> Yes <input type="checkbox"/> 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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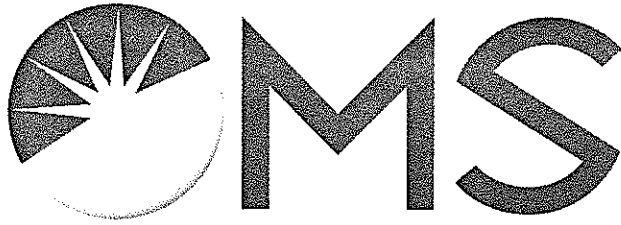
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13. Do you **currently** have any of the following hearing problems? Yes No ~ Difficulty hearing
 Yes No ~ Other hearing/ear problem Yes No ~ Wear hearing aid
14. Yes No ~ Have you **ever had** a back injury?
15. Do you **currently** have any of the 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

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 ~ Less than 5 hrs **per week**
- Yes No ~ 2 to 4 hrs per day
- Yes No ~ Emergency rescue only
- Yes No ~ Less than 2 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):

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998]