OSHA Respirator Medical Evaluation Questionnaire (Mandatory) Appendix C to Sec. 1910.134:

Part A. Section 1. (Mandatory) Every employee who has been selected to use any type of respirator (please print) must provide the following information.

Today's date _____ Date of Birth: _____

Name _____ SSN: _____

Job Title _____ Sex: Male ◯ Female ◯

Home Phone: _____ Height: ____(ft) ____(in) Weight _____ (lbs)

Work Phone: _____

Can you read English? . . . . . **Yes** ◯ **NO** ◯

Has your employer told you how to contact the health care professional who will review this? **Yes** ◯ **NO** ◯

Check the type of respirator you will use (you can check more than one category):

a ___ N, R, or P disposable respirator (filter-mask, non-cartridge type only).

b ___ Other type

☐ Half-face ☐ Powered-air purifier

☐ Full-facepiece type (includes gas mask) ☐ Self-contained breathing apparatus

Have you worn a respirator in the past?: . . . . . **Yes** ◯ **NO** ◯

If ``yes,'' what type(s): _____

Physical exertion while wearing a respirator ☐ Mild ☐ Moderate ☐ Strenuous

Maximum time you wear a respirator in a single day?: _____ hours

Do you exercise? . . . . . **Yes** ◯ **NO** ◯

If ``yes,' describe how often and what exercise activities are: _____

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 ``yes'' or ``no'').

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? **Yes** ◯ **NO** ◯

If Yes, how many packs per day? ☐ 1/2 or less ☐ 1 ☐ 2 ☐ 2 or more

How many years have you smoked? ☐ 1-9 ☐ 10-19 ☐ 20-29 ☐ 30 or more

2. Have you ever had any of the following conditions?

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 **Yes** ◯ **NO** ◯

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

Asbestosis **Yes** ◯ **NO** ◯

Asthma **Yes** ◯ **NO** ◯

Chronic bronchitis: **Yes** ◯ **NO** ◯

Emphysema: **Yes** ◯ **NO** ◯

Pneumonia **Yes** ◯ **NO** ◯

Tuberculosis **Yes** ◯ **NO** ◯

Silicosis **Yes** ◯ **NO** ◯

Pneumothorax (collapsed lung) **Yes** ◯ **NO** ◯

Lung cancer **Yes** ◯ **NO** ◯

Broken ribs: **Yes** ◯ **NO** ◯

Any chest injuries or surgeries: **Yes** ◯ **NO** ◯

Any other lung problem that you've been told about: **Yes** ◯ **NO** ◯

Name _____

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

Shortness of breath:	Yes ◯ NO ◯
Shortness of breath when walking fast on level ground or walking up a slight hill/incline	Yes ◯ NO ◯
Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes ◯ NO ◯
Have to stop for breath when walking at your own pace on level ground:	Yes ◯ NO ◯
Shortness of breath when washing or dressing yourself:	Yes ◯ NO ◯
Shortness of breath that interferes with your job:	Yes ◯ NO ◯
Coughing that produces phlegm (thick sputum):	Yes ◯ NO ◯
Coughing that wakes you early in the morning:	Yes ◯ NO ◯
Coughing that occurs mostly when you are lying down:	Yes ◯ NO ◯
Coughing up blood in the last month:	Yes ◯ NO ◯
Wheezing:	Yes ◯ NO ◯
Wheezing that interferes with your job:	Yes ◯ NO ◯
Chest pain when you breathe deeply:	Yes ◯ NO ◯
Any other symptoms that you think may be related to lung	Yes ◯ NO ◯

5. Have you ever had any of the following cardiovascular or heart problems?

Heart attack	Yes ◯ NO ◯
Stroke:	Yes ◯ NO ◯
Angina:	Yes ◯ NO ◯
Heart Failure:	Yes ◯ NO ◯
Swelling in your legs or feet (not caused by walking):	Yes ◯ NO ◯
Heart arrhythmia (heart beating irregularly):	Yes ◯ NO ◯
High blood pressure:	Yes ◯ NO ◯
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?

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 symptoms that is not related to eating	Yes ◯ NO ◯
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?

Breathing or lung problems:	Yes ◯ NO ◯
Heart trouble:	Yes ◯ NO ◯
Blood Pressure:	Yes ◯ NO ◯
Seizures(fits)::	Yes ◯ NO ◯

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)

Eye irritation:	Yes ◯ NO ◯
Skin allergies or rashes:	Yes ◯ NO ◯
Anxiety:	Yes ◯ NO ◯
General weakness or fatigue:	Yes ◯ NO ◯
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 this questionnaire about your answers to this questionnaire: Yes ◯ NO ◯

Name _____

SUPPLEMENTAL: If you are required to use a full-face peice respirator or a Self-Contained Breathing Aparatus (SCBA), complete the following: (If you do not, please sign below.)

10. Have you ever lost vision in either eye (temporarily or permanently): Yes ◯ NO ◯

11. Do you currently have any of the following vision problems?

Wear glasses: Yes ◯ NO ◯
Wear contact lenses: Yes ◯ NO ◯
Color blind: Yes ◯ NO ◯
Any other eye or vision problem: Yes ◯ NO ◯

12. Have you ever had an injury to your ears, including a broken ear drum: Yes ◯ NO ◯

13. Do you currently have any of the following hearing problems?

Difficulty hearing: Yes ◯ NO ◯
Wear a hearing aid: Yes ◯ NO ◯
Any other hearing or ear problem: Yes ◯ NO ◯

14. Have you ever had a back injury: Yes ◯ NO ◯

15. Do you currently have any of the following musculoskeletal problems?

Weakness in any of your arms, hands, legs, or feet: Yes ◯ NO ◯
Back pain: Yes ◯ NO ◯
Difficulty fully moving your arms and legs: Yes ◯ NO ◯
Pain or stiffness when you lean forward or backward at the waist: Yes ◯ NO ◯
Difficulty fully moving your head up or down: Yes ◯ NO ◯
Difficulty fully moving your head side to side: Yes ◯ NO ◯
Difficulty bending at your knees: Yes ◯ NO ◯
Difficulty squatting to the ground: 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 ◯

Any additional comments you would like to make:

_____

To the best of my knowledge, the information I have provided is true and accurate.

Employee Signature _____ **Date** _____

TO BE COMPLETED BY THE EXAMINER/REVIEWER:

This employee has been found to be physically able to use the following (check each [ ] that applies):

- ☐ Single use, filter mask (four attachment points)
- ☐ Half-faced cartridge-type, negative pressure
- ☐ Full-faced cartridge-type respirator, negative pressure
- ☐ Half-faced powered cartridge-type (PAPR)
- ☐ Full-faced powered cartridge-type (PAPR)
- ☐ Self-contained breathing apparatus (SCBA)
- ☐ Hood/helmet powered cartridge-type (PAPR)
- ☐ Half-faced/Full-faced/Hood/Helmet (NOT positive pressure)

Restrictions / Limitations (if any) when wearing a respirator:

_____

- ☐ ***This employee has been found to be physically NOT able to use a respirator***
- ☐ ***There is insufficient information to make a determination at this time***
- ☐ ***The mandatory questionnaire has been reviewed, and the employee has been found to be physically able to use a respirator.***
- ☐ ***The mandatory questionnaire has been reviewed but there is insufficient information to make a determination at this time.***

This respirator clearance expires 1 ◯ 2 ◯ 3 ◯ years from the date below. (*If not marked, clearance expires in 1 year*)

_____ _____ _____

Reviewer's Name (Print) **Reviewer's Signature** **Date:**

Reset Form