



OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

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

To the employee: Answer to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

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 must be provided by every employee who has been selected to use any type of respirator (**PLEASE PRINT**).

Name: _____ Employee ID #: _____ Date: _____

DOB: _____ Sex: Male Female Height: _____ Weight: _____

Department: _____ Job title: _____

Phone number: (include the Area Code): (_____) _____ Best time to reach you: _____

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

- N, R, or P disposable respirator (filter-mask, non-cartridge type only).
- Other type (for example, half-facepiece or full-facepiece type, powered-air purifying, supplied-air, self-breathing apparatus).

Have you worn a respirator (check one): No Yes – If **YES** what type (s): _____

How often? _____

Part A. Section 2. (Mandatory) Questions below must be answered by every employee who has been selected to use any type of respirator (please check **either YES or NO**). Please **explain** any **YES** answers in the space provided or on a separate sheet.

1. Do you CURRENTLY smoke tobacco, or have you smoked tobacco in the last month?

No Yes _____

2. Have you EVER HAD any of the following conditions?

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

3. Have you EVER HAD any of the following pulmonary or lung problems?

- No Yes Asbestosis..... _____
- No Yes Asthma _____
- No Yes Chronic bronchitis..... _____
- No Yes Emphysema..... _____
- No Yes Pneumonia _____
- No Yes Tuberculosis _____
- No Yes Silicosis..... _____
- No Yes Pneumothorax (collapsed lung) _____
- No Yes Lung cancer _____
- No Yes Broken ribs _____
- No Yes Any chest injuries or surgeries _____
- No Yes Any other lung problem that you've been told about _____

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

- No Yes Shortness of breath _____
- No Yes Shortness of breath when walking fast on level ground or walking up a slight hill or incline

- No Yes Shortness of breath when walking with other people at an ordinary pace on level ground

- No Yes Have to stop for breath when walking at your own pace on level ground

- No Yes Shortness of breath when washing or dressing yourself

- No Yes Shortness of breath that interferes with your job..... _____
- No Yes Coughing that produces phlegm (thick sputum) _____
- No Yes Coughing that wakes you early in the morning _____
- No Yes Coughing that occurs mostly when you are lying down

- No Yes Coughing up blood in the last month..... _____
- No Yes Wheezing _____
- No Yes Wheezing that interferes with your job..... _____
- No Yes Chest pain when you breathe deeply _____
- No Yes Any other symptoms that you think may be related to lung problems

5. Have you EVER HAD any of the following cardiovascular or heart problems?

- No Yes Heart attack..... _____
- No Yes Stroke
- No Yes Angina.....
- No Yes Heart failure.....
- No Yes Swelling in your legs or feet (not caused by walking)
- No Yes Heart arrhythmia (heart beating irregularly)
- No Yes High blood pressure.....
- No Yes Any other heart problem that you've been told about

6. Have you EVER HAD any of the following cardiovascular or heart symptoms?

- No Yes Frequent pain or tightness in your chest
- No Yes Pain or tightness in your chest during physical activity

- No Yes Pain or tightness in your chest that interferes with your job

- No Yes In the past two years, have you noticed your heart skipping or missing a beat

- No Yes Heartburn or indigestion that is not related to eating
- No Yes 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?

- No Yes Breathing or lung problems
- No Yes Heart trouble
- No Yes Blood pressure
- No Yes Seizures (fits).....

8. If you've used a respirator, have you EVER HAD any of the following problems with respirator use?

- No Yes **(If you've never used a respirator, check the following space and go to question 9)**
- No Yes Eye irritation.....
- No Yes Skin allergies or rashes.....
- No Yes Anxiety
- No Yes General weakness or fatigue
- No Yes Any other problem that interferes with your use of a respirator

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

- No Yes

Questions below **must** be answered by every employee who has been selected to use either a full facepiece 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. Have you EVER LOST vision in either eye (temporarily or permanently)?

No Yes

11. Do you CURRENTLY have any of the following vision problems

No Yes Wear contact lenses

No Yes Wear glasses.....

No Yes Color blind

No Yes Any other eye or vision problems

No Yes Are glasses necessary during respirator use

12. Have you EVER HAD any injury to your ears, including a broken ear drum?

No Yes

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

No Yes Difficulty hearing

No Yes Wear a hearing aid.....

No Yes Any other hearing or ear problem

14. Have you EVER HAD a back injury?

No Yes

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

No Yes Weakness in any of your arms, hands, legs, or feet....

No Yes Back pain

No Yes Difficulty fully moving your arms and legs

No Yes Pain or stiffness when you lean forward or backward at the waist

No Yes Difficulty fully moving your head up or down.....

No Yes Difficulty fully moving your head side to side

No Yes Difficulty bending at your knees.....

No Yes Difficulty squatting to the ground.....

No Yes Climbing a flight of stairs or a ladder carrying more than 25 lbs

No Yes Any other muscle or skeletal problem that interferes with using a respirator

**Please Be Certain to Explain All Positive Responses
Before Returning This Questionnaire**