OSHA Respirator Medical Evaluation Questionnaire (Mandatory)
(Appendix C to Section 1910.134)

To the Employee: Can you read (circle one)? Yes No

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).

1. Today's date: _____

2. Your name: _____

3. Date of Birth: ___/___/_____ 4. Sex: Male Female

5. Your height: _____ ft. ____ in. 6. Your weight: _____ lbs.

7. Your job title: _____

8. A phone number where you can be reached by the healthcare professional who reviews this questionnaire (include the area code): _____.

9. 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 (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

10. Have you worn a respirator? (circle one): Yes No

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. Circle 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 (fits)?	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

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. Must stop for breath when walking at your own pace on level ground	Yes	No
e. Shortness of breath when washing/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 symptom 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 (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 here _____ and go on to question 9.)

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 healthcare professional who will review this questionnaire about your answers to this questionnaire? Yes No

Part B 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. Have you ever lost vision in either eye (temporarily or permanently)? Yes No

11. Do you currently have any of the following vision problems? Yes No

    a. Wear contact lenses Yes No
    b. Wear glasses Yes No
    c. Color blindness Yes No
    d. Any other eye or vision problem Yes No

12. Have ever had an injury to your ears, including a broken eardrum? Yes No

13. Do you currently have any of the following hearing problems? Yes No

    a. Difficulty hearing Yes No

    b. Wear a hearing aid Yes No

    c. 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? Yes No

    a. Weakness in any of your arms, hands, legs, or feet Yes No
    b. Back pain Yes No
    c. Difficulty fully moving your arms and legs Yes No
    d. Pain and stiffness when you lean forward or backward at the waist Yes No
    e. Difficulty fully moving your head up or down Yes No
    f. Difficulty fully moving your head side to side Yes No
    g. Difficulty bending at your knees Yes No
    h. Difficulty squatting to the ground Yes No
    i. Climbing a flight of stairs or a ladder carrying more than 25 lbs. Yes No
    j. Any other muscle or skeletal problem that interferes with using a respirator Yes No

_____

Employee Signature Date