

# 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):

<b>a</b>	___	N, R, or P disposable respirator (filter-mask, non-cartridge type only).	
<b>b</b>	___	Other type	<input type="checkbox"/> Powered-air purifier
	<input type="checkbox"/>	Half-face	<input type="checkbox"/> Supplied-air
	<input type="checkbox"/>	Full-facepiece type (includes gas mask)	<input type="checkbox"/> 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

**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

**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):***

- |  |  |
|--|--|
| <input type="checkbox"/> Single use, filter mask (four attachment points)        | <input type="checkbox"/> Full-faced powered cartridge-type (PAPR)                  |
| <input type="checkbox"/> Half-faced cartridge-type, negative pressure            | <input type="checkbox"/> Self-contained breathing apparatus (SCBA)                 |
| <input type="checkbox"/> Full-faced cartridge-type respirator, negative pressure | <input type="checkbox"/> Hood/helmet powered cartridge-type (PAPR)                 |
| <input type="checkbox"/> Half-faced powered cartridge-type (PAPR)                | <input type="checkbox"/> 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:** \_\_\_\_\_