Name: _____ **Date of Birth:** _____/_____/_____

Company: _____ **Wear SCBA? Y_____ N_____**

Medical Expiration Date: _____ **MRN:** _____

**** Please complete entire questionnaire, including Part B**

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)
To the employer: Answers to questions in Section 1 and to question 9 in Section 2 of Part A do not require a medical examination.

To the employee: 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.
Please answer ALL questions.

Please include a phone number where you can be reached during the day. If the provider reviewing your questionnaire needs further information, they will call you at the number you list. Please answer the call if possible or return the call as soon as possible.

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. Your date of birth _____ Age (to nearest year): _____
4. **Sex** (circle one): Male/Female
5. Your height: _____ft. _____ in.
6. Your weight: _____lbs.
7. Your job title: _____
8. A phone number where you can be reached between 8 AM to 5 PM by the health care professional who reviews this questionnaire (include the Area Code): _____
8a. Is it ok to leave a detailed message at the number you listed? ☐**Yes** ☐**No**
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire (check the box): ☐**Yes** ☐**No**

11. 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-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (check the box): ☐**Yes** ☐**No**
If "yes," what type(s): _____
_____

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 check "yes" or "no").

Name _____ DOB _____

	Yes	No
1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month:	☐	☐

2. Have you **ever had** any of the following conditions?	Yes	No
a. Seizures (fits):	☐	☐
b. Diabetes (sugar disease):	☐	☐
c. Allergic reactions that interfere with your breathing:	☐	☐
d. Claustrophobia (fear of closed-in places):	☐	☐
e. Trouble smelling odors:	☐	☐

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

	Yes	No
a. Asbestosis:	☐	☐
b. Asthma:	☐	☐
c. Chronic bronchitis:	☐	☐
d. Emphysema:	☐	☐
e. Pneumonia:	☐	☐
f. Tuberculosis:	☐	☐
g. Silicosis:	☐	☐
h. Pneumothorax (collapsed lung):	☐	☐
i. Lung cancer:	☐	☐
j. Broken ribs:	☐	☐
k. Any chest injuries or surgeries:	☐	☐
l. 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?

	Yes	No
a. Shortness of breath:	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground:	☐	☐
d. Have to stop for breath when walking at your own pace on level ground:	☐	☐
e. Shortness of breath when washing or dressing yourself:	☐	☐
f. Shortness of breath that interferes with your job:	☐	☐
g. Coughing that produces phlegm (thick sputum):	☐	☐
h. Coughing that wakes you early in the morning:	☐	☐
i. Coughing that occurs mostly when you are lying down:	☐	☐
j. Coughing up blood in the last month:	☐	☐
k. Wheezing:	☐	☐
l. Wheezing that interferes with your job:	☐	☐

Name _____ DOB _____

m. Chest pain when you breathe deeply:	☐	☐
n. 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?

	Yes	**No**
a. Heart attack:	☐	☐
b. Stroke:	☐	☐
c. Angina:	☐	☐
d. Heart failure:	☐	☐
e. Swelling in your legs or feet (not caused by walking):	☐	☐
f. Heart arrhythmia (heart beating irregularly):	☐	☐
g. High blood pressure:	☐	☐
h. Any other heart problem that you've been told about:	☐	☐

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

	Yes	**No**
a. Frequent pain or tightness in your chest:	☐	☐
b. Pain or tightness in your chest during physical activity:	☐	☐
c. Pain or tightness in your chest that interferes with your job:	☐	☐
d. In the past two years, have you noticed your heart skipping or missing a beat:	☐	☐
e. Heartburn or indigestion that is not related to eating:	☐	☐
f. 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?

	Yes	**No**
a. Breathing or lung problems:	☐	☐
b. Heart trouble:	☐	☐
c. Blood pressure:	☐	☐
d. 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 box and go to question 9) ☐

a. Eye irritation:	☐	☐
b. Skin allergies or rashes:	☐	☐
c. Anxiety:	☐	☐
d. General weakness or fatigue	☐	☐
e. 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: ☐**Yes** ☐**No**

Name _____ DOB _____

- -

Questions 10 to 15 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. Please answer questions in Part B.

	Yes	No
10. Have you **ever lost** vision in either eye (temporarily or permanently):	☐	☐

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

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

	Yes	No
12. Have you **ever had** an injury to your ears, including a broken ear drum:	☐	☐

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

	Yes	No
a. Difficulty hearing:	☐	☐
b. Wear a hearing aid:	☐	☐
c. Any other hearing or ear problem:	☐	☐

14. Have you **ever had** a back injury:	☐	☐

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

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

Name _____ DOB _____

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. Please answer the following questions:

1. 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) ☐**Yes** ☐**No**

   If "yes", name the medications: _____
_____

2. How often do you expect to use the respirator(s). Mark all that apply to you:

		Yes	**No**
a.	Escape only (no rescue):	☐	☐
b.	Emergency rescue only:	☐	☐
c.	Less than 5 hours *per week*:	☐	☐
d.	Less than 2 hours *per day*:	☐	☐
e.	2 to 4 hours per day:	☐	☐
f.	Over 4 hours per day:	☐	☐

3. During the period you are using the respirator(s), is your work effort:
   a. *Light* (less than 200 kcal/hr): ☐**Yes** ☐**No**
      If "yes", how long does this period last during the average shift:
      _____ hrs. _____ mins.

      Examples of a light work effort are *sitting* while writing, drafting, or performing light assembly work; or *standing* while operating a drill press (13 lbs.) or controlling machines.

   b. *Moderate* (200 – 350 kcal/hr): ☐**Yes** ☐**No**
      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, or 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; or *pushing* a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

   c. *Heavy* (above 350 kcal/hr): ☐**Yes** ☐**No**
      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

Name _____ DOB _____

chipping castings; *walking* up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

4. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator? ☐**Yes** ☐**No**

If "yes", describe this protective clothing or equipment: _____

5. Will you be working under hot conditions (temperature exceeding 77 deg F) ☐**Yes** ☐**No**

6. Will you be working under humid conditions: ☐**Yes** ☐**No**

7. Describe the work you'll be doing while you're using your respirator(s): _____

_____