

Occupational Medical Services

Appendix C to 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 employed:

Can you read? 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.

Company Name: _____

Part A. Section 1. (Mandatory)

1. Today's date: ___/___/___
2. Social Security #: _____-_____-_____
3. Your name: _____
4. Your age (to nearest year): _____
5. Sex: Male Female
6. Your job title: _____
7. A phone number where you can be reached by the health care professional who reviews this questionnaire. Including the area code (_____) _____-_____
8. The best time to phone you at this number: Before _____ After _____ Between _____
9. Has your employer told you how to contact the health care professional who will review this questionnaire? Yes No
10. Check the type of respirator you will use (you can check more than 1 category):
 - a. N R P disposable respirator (filter-mask, non-cartridge type only)
 - b. Other type (for example, half or full-face piece, powered-air purifying, supplied-air, self-contained breathing apparatus)
11. Have you worn a respirator? Yes No If yes, what type: _____

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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.

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 spaces): Yes No
 - e. Trouble smelling odors: Yes No
3. 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 have 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. Have to stop for breath when walking at your own pace on level ground: Yes No
 - e. Shortness of breath when washing or 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 you 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 problems 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 2 years, have you noticed your heart skipping or missing a beat: Yes No
 - e. Heartburn or indigestion not related to eating: Yes No
 - f. 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?
- 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 the following space and go to question 9)
- Never Used
 - 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 health care professional who will review this questionnaire about your answers to this questionnaire?
 Yes No

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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.

- | | | |
|---|------------------------------|-----------------------------|
| 10. Have you ever lost vision in either eye (temporarily or permanently): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Do you currently have any of the following vision problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| a. Wear contact lenses: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Wear glasses: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Color blind: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Any other eye or vision problem: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Have you ever had an injury to your ears, including a broken ear drum: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Do you currently have any of the following hearing problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| a. Difficulty hearing: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Wear hearing aid: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Any other hearing or ear problem: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Have you ever had a back injury? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Do you currently have any of the following musculoskeletal problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| a. Weakness in any of your arms, hands, legs, or feet: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Back pain: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Difficulty fully moving your arms and legs: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Pain or stiffness when you lean forward or backward at the waist: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Difficulty fully moving your head up or down: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Difficulty fully moving your head side to side: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Difficulty bending at your knees: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Difficulty squatting to the ground: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Any other musculoskeletal problem that interferes with wearing a respirator: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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.

- 1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen?**

Yes No

If "Yes", do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you are working in these conditions:

Yes No

- 2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust) or have you come into skin contact with hazardous chemicals?**

Yes No

If "Yes", name the chemicals if you know them:

- 3. Have you ever worked with any of the materials, or under any of the conditions, listed below:**

- | | | |
|--|------------------------------|-----------------------------|
| a. Asbestos: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Silica (e.g., sandblasting): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Tungsten/ cobalt (e.g., grinding or welding this material): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Beryllium: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Aluminum: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Coal (e.g., mining): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Iron: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Tin: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Dusty environments: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Any other hazardous exposures: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If "Yes", describe these exposures:

- 4. List any second jobs or businesses you have:** _____

- 5. List your previous occupation:** _____

- 6. List your current and previous hobbies:** _____

- 7. Have you ever been in the military service?** Yes No

If "Yes", were you exposed to biological or chemical agents (either in training or combat):

Yes No

- 8. Have you ever worked on a HAZMAT team?** Yes No

- 9. 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 if you know them:

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10. Will you be using any of the following items with your respirator:

- a. HEPA filters: Yes No
- b. Canisters (for example, gas masks): Yes No
- c. Cartridges: Yes No

11. How often are you expected to use the respirator (check all that apply):

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

12. During the period you are using the respirator, is your work effort:

- a. Light (less than 200 kcal per hour): Yes No
If "Yes", how long does this period last during the average shift: ____hrs ____min
Examples of light work effort are **sitting** while writing, typing, drafting, or performing light assembly work or **standing** while operating a drill press (1-3 lbs) or controlling machines.
- b. Moderate (200-350 kcal per hour): Yes No
If "Yes", how long does this period last during the average shift: ____hrs ____min
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, or **walking** on a level surface or down 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 per hour) Yes No
If "Yes", how long does this period last during the average shift: ____hrs ____min
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 chipping castings, **walking** up an 8 degree grade about 2 mph, **climbing** stairs with a heavy load (about 50 lbs).

13. 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 and/or equipment: _____

14. Will you be working under hot conditions (temperature exceeding 77° F)?:

Yes No

15. Will you be working under humid conditions?:

Yes No

16. Describe the work you'll be doing while wearing your respirator:

17. Describe any special or hazardous conditions you might encounter when you are using your respirator (for example, confined spaces, life-threatening gases): _____

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator:

Name of toxic substance: _____
Estimated maximum exposure level per shift: _____ Duration of exposure per shift: _____

Name of toxic substance: _____
Estimated maximum exposure level per shift: _____ Duration of exposure per shift: _____

Name of toxic substance: _____
Estimated maximum exposure level per shift: _____ Duration of exposure per shift: _____

The name of any other toxic substances that you'll be exposed to while wearing your respirator: _____

19. Describe any special responsibilities you'll have while using your respirator that may affect the safety and well-being of others (for example, rescue, security): _____
