Occupational Health Group

MEDICAL EVALUATION FOR RESPIRATOR USE (OSHA MANDATORY QUESTIONNAIRE)

Reference 29CFR1910.134, Appendix C

To the employee: 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.

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).

Employee Name	Social Security Number	Age	Today's Date

Male Female _____' _____" _____ _____

Sex Height Weight Job Title

Phone number where the health care professional who reviews this questionnaire can call you (include the Area Code): _____. Best time to phone you at this number _____am or pm (circle one)

Has your employer told you how to contact the health care professional who will review this questionnaire (check one): oYes oNo

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 (Example, half- / full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Have you worn a respirator (check one): **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").

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

(continued from Page 1) Have you ever had any of the following pulmonary or lung problems?

- 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 or incline.. Yes No

Shortness of breath when walking at your own pace on level ground…… Yes No

Have to stop for breath when walking with other people at an ordinary 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 problems…… 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 indigestion 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. Have you used a respirator ?…… Yes No

If NO, go to question 9.

If YES, have you ever had any of the following problems?

Eye irritation…… Yes No

Skin allergies or rashes…… Yes No

Anxiety…… Yes No

General weakness or fatigue…… Yes No

Any other problems that interfere with your use of a respirator…… Yes No

9. Would you like to talk to the health care profesional who will review this questionnaire about your answers to this questionnaire…… Yes No

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) ..... Yes No

11. Do you currently have any of the following vision problems?
    - Wear contact lenses..... Yes No
    - Wear glasses..... 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