OSHA RESPIRATOR MEDICAL QUESTIONNAIRE

Appendix C to 1910.134: OSHA Respiratory Medical Evaluation Questionnaire (Revised 8/12/20 HMH OH)

This section for Occupational Health Official Use ONLY: LHCP Decision:

1. ___ Medically qualified for respirator use without restriction for 2 years.
2. ___ Medically qualified for respirator use with the following restrictions:_____________________________
3. ___ Defer decision, additional information required.
   a. Telephone call for clarification
   b. Needs medical evaluation, office visit to be scheduled
4. ___ Not medically qualified to use respirator.

This form was reviewed and based upon the accuracy of the information provided respirator use is approved as of this date. Comment:____.

Reviewed by: ____ Approval Date: ___________

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Can you read English? (circle one): Yes / No

Employer: ____

Your manager/supervisor must allow you to answer this questionnaire during normal working hours, or at a time and place this is convenient for you. To maintain confidentiality, your manager/supervisor must not look at or review your answers, and she or he must tell you how to send this to the health care professional who will review it.

Please check of the **type of respirator** will you be required to wear: If you don't know which respirator you will be required to wear please consult your employer. You may check more than one.

__ Half face mask (paper filter mask, covers nose and mouth, no cartridge, i. e. N-95, particulate dust mask)
__ Half face mask (covers nose and mouth, made of rubber, with cartridge)
__ Full face mask (covers full face, made of rubber, with cartridge)
__ Powered Air Purifying (hood or full face mask with filtered air supply)
__ SCBA (self contained breathing apparatus, i.e. Scott Pack)

Part A. Section 1. (Mandatory) Every employee who has been selected to use *any* type of respirator must, according to OSHA regulations, provide the following information. This information is not required for employees who voluntarily use dust masks for protection against nuisance dust.

PLEASE PRINT:

1. **Date:** ____________________________
2. **Name:** __________________________________
3. **Street/City/ZipCode**: ____
4. **Date of birth:** _________________

Name: ___________________________________

5. Sex (circle one) Male / Female

6. Height: ________________ ft. __________ inches

7. Weight: ____________________ lbs

8. Job title: ____

9. Phone number where you can be reached by the health care professional who reviews this questionnaire (include area code): _______________________________

10. The best time to phone you at this number: ___________________

11. Has your supervisor/manager told you how to contact the health care professional who will review this questionnaire? (circle one) Yes No

12. Have you worn a respirator before? (circle one) Yes / No For how many years? _________________

If "yes" what type? (see above) _______________________
For what purpose? (Circle one) **Escape** **Rescue**

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Part A. Section 2. (Mandatory) Every employee who has been selected to use **any** type of respirator must answer questions 1 through 9. **All "Yes" responses require detailed explanation in area provided on page 6.**

			CIRCLE YES OR NO
1.	Do you currently smoke tobacco, or have you smoked tobacco in the last month?		Yes No
	How many packs? ______ How many years? _____		
2.	Have you ever had any of the following conditions?		
a.	Seizures (fits)		Yes No
b.	Diabetes (sugar disease)		Yes No
c.	Allergic reaction that interfere with your breathing		Yes No
d.	Claustrophobia (fear of closed-in places)		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.	Pneumothrorax (collapsed lung)		Yes No
i.	Lung Cancer		Yes No
j.	Broken ribs		Yes No
k.	Any chest injuries or surgeries		Yes No
l.	Any 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 your legs or feet not caused by walking		Yes No
f.	Hear arrhythmia (heart beating irregularly)		Yes No
g.	High blood pressure		Yes No
h.	Any other heart problem that you have been told about		Yes No
6.	**Have you ever had any of the following cardiovascular or heart symptoms?**		Yes No
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 symptoms that you think may be related to heart or circulation problems		Yes No
	Do you currently take any medication?		Yes No
7.	**Do you take medication for any of the following problems?**		Yes No
a.	Breathing or lung problems		Yes No
b.	Heart trouble		Yes No
c.	Blood pressure		Yes No
d.	Seizures (fits)		Yes No
e.	Seasonal allergies, hay fever, etc.		Yes No
8.	**If you've used a respirator, have you ever had any of the following problems?**		
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 problems that interferes with the use of your respirator		Yes No
9.	**Would you like to talk to the health care professional who will review this questionnaire about your answers to this question?**		Yes No

QUESTIONS 10-15

THESE QUESTIONS MUST BE ANSWERED BY EVERY EMPLOYEE WHO IS REQUIRED TO USE EITHER A FULL-FACE 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 blind		Yes No
d.	Any other eye or vision problem		Yes No
12.	**Have you ever had an injury to your ears, including a broken eardrum?**		Yes No
13.	**Do you currently have any of the following hearing problems?**		
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?**		
	Weakness in any of your arms, hands, legs, or feet		Yes No
	Back pain		Yes No
	Difficult moving your arms and legs		Yes No
	Pain or stiffness when you lean forward or backward at the waist		Yes No
	Difficulty moving your head up or down		Yes No
	Difficulty 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 pounds		Yes No
	Any other muscle or skeletal problem that interferes with using a respirator		Yes No
16.	**Have you fainted or passed out, or had periods of unconsciousness in the past year?**		Yes No

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Part B.

If you are required to wear your respirator in a confined space, at low oxygen levels, in heated environments or during activities involving exposure to hazardous materials or chemicals, or in situations dealing with conditions that impose an immediate danger to life or health, please answer the following questions. 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're working under 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: (circle yes or no)

   a. Asbestos: Yes No
   b. Silica (e.g., in sandblasting): Yes No

   c. Tungsten/Cobalt (e.g., grinding or welding this material: Yes No

   d. Beryllium: Yes No
   e. Aluminum: Yes No
   f. Coal (for example, mining): Yes No
   g. Iron: Yes No
   h. Tin: Yes No
   i. Dusty environments: Yes No
   j. Any other hazardous exposures: Yes No

If "yes" describe these exposures: ____

____

4. List any second jobs or side businesses you have: ____

____

5. List your previous occupations; ____

____

6. List your current and previous hobbies: ____

7. Have you been in the military services? 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 troubles, 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

10. Will you be using any of the following items with your respirator(s)?

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(s)?

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(s), 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. __________mins.

Examples of a 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 to 350 kcal per hour): 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 per hour) : 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 shipping 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

14. Will you be working under hot conditions (temperature exceeding 77 degrees F)

Yes No

15. Will you be working under humid conditions:

Yes No

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

____

____

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (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 (s):
Name of the first toxic substance: ___________________________________

Estimated maximum exposure level per shift: ___________________________

Duration of exposure per shift: _____________________________________

Name of the second toxic substance: _________________________________

Estimated maximum exposure level per shift: ___________________________

Duration of exposure per shift: ______________________________________

Name of the third toxic substance: ___________________________________

Estimated maximum exposure level per shift: ___________________________

Duration of exposure per shit: __________________________________

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

____

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

____

PLEASE EXPLAIN ALL "YES" RESPONSES

Number	Explanation

I, the undersigned, shall report to management any changes in my health condition that are related to my ability to use a respirator and certify that the answers to the above questions are true to the best of my knowledge.

Employee's Signature: ____ Date: _____________________