

**U.S. PUBLIC HEALTH SERVICE
FEDERAL OCCUPATIONAL HEALTH**

**OSHA Respirator Medical Evaluation Questionnaire (Mandatory)
Appendix C to Sec. 1910.134:**

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:

Can you read? (select one):

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). Today's date _____

Name

Job Title

Age Male/ Female
(circle one)

Height (ft, in)

Weight (lbs)

A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):

The best time to phone you at this number:

Has your employer told you how to contact the health care professional who will review this questionnaire (select one):
Yes No

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

half- face

full-facepiece type,

powered-air purifying,

supplied-air,

self-contained breathing apparatus.

Have you worn a respirator (select 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 select "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
- 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 or 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:
Heart trouble:
Blood pressure:
Seizures (fits):

Yes No
Yes No
Yes No
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:
Skin allergies or rashes:
Anxiety:
General weakness or fatigue:
Any other problem that interferes with your use of a respirator:

Yes No
Yes No
Yes No
Yes No
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

Questions 10-15 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:
Wear glasses:
Color blind:
Any other eye or vision problem:

Yes No
Yes No
Yes No
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:
Wear a hearing aid:
Any other hearing or ear problem:

Yes No
Yes No
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:
Back pain:
Difficulty fully moving your arms and legs:
Pain or stiffness when you lean forward or backward at the waist:
Difficulty fully moving your head up or down:
Difficulty fully moving your head side to side:
Difficulty bending at your knees:
Difficulty squatting to the ground:
Climbing a flight of stairs or a ladder carrying more than 25 lbs:
Any other muscle or skeletal problem that interferes with using a respirator:

Yes No
Yes 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'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: _____

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

Substance/Conditions	Description of exposure (only if answer is yes)	
Asbestos	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Silica (e.g., in sandblasting)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tungsten/cobalt (e.g., grinding or welding this material)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Beryllium:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Aluminum	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Coal (for example, mining)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Iron:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tin:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dusty environments:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any other hazardous exposures:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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 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: _____

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

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) (select "yes" or "no" for all answers that apply to you)?:

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:

Light (less than 200 kcal per hour): Yes <input type="checkbox"/> No <input type="checkbox"/>	If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.
<i>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</i>	
Moderate (200 to 350 kcal per hour): Yes <input type="checkbox"/> No <input type="checkbox"/>	If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.
<i>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.</i>	
Heavy (above 350 kcal per hour): Yes <input type="checkbox"/> No <input type="checkbox"/>	If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.
<i>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.).</i>	

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 deg. 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 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 using your respirator:

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

To the best of my knowledge, the information I have provided is true and accurate.

Employee Name

Date

Employee Signature

Employee name: _____ Age _____ Sex _____ Date of birth: _____
 Agency: _____ Work location: _____ Job title: _____
 Supervisor's name: _____ Supervisor's phone: _____ fax: _____
 Type of respirator use requested: __disposable, __negative pressure (cartridge), __PAPR, __airline, __SCBA

I. Basis for recommendations on respirator clearance:

Recommendations below on medical clearance for respirator use are based on a review of (check all that apply):

- Mandatory OSHA Respirator Medical Evaluation Questionnaire
- Records of a medical examination, including physical exam, done on: _____
- Additional information supplied by employee's personal physician.
- Other information (specify): _____

II. Recommendations on medical clearance for respirator use: (Choose A, B or C below)

A. The employee is given medical clearance to use the following respirator(s) under the conditions noted (choose all that apply)

<input type="checkbox"/> N, R or P disposable respirator (filter-mask, non-cartridge type only)	<input type="checkbox"/> Supplied air (air line) respirator
<input type="checkbox"/> Negative pressure air-purifying (cartridge) respirator -- either half- or full-face	<input type="checkbox"/> Self-contained breathing apparatus (SCBA)
<input type="checkbox"/> Powered air purifying respirator (PAPR) -- either half or full face	

When using respirators, the employee is approved to perform the following (choose one)

- Mild exertion /low heat stress
- Moderate exertion
- Heavy exertion
- Escape only
- Normal job duties
- Other Activity _____

Mild exertion (2-3 mets) e.g. lifting up to 10 lbs, extended walking on a flat surface, extended standing

Moderate exertion (4-5 mets) e.g. lifting 10 lbs, 5 lifts per min, fast walking (4 mph), gardening/digging, pushing, pulling

Heavy exertion (5-10 mets) e.g. jogging (10 min/mi), chopping wood, climbing hills, life-saving activities, fire fighting

This respirator clearance expires (circle one) 1 2 3 4 5 years from the date below (If not marked, clearance expires in 1 year)

B. The employee is not given medical clearance for respirator use because more information is needed (Specify what is needed to make a decision)

- 1. A medical examination, including a physical exam*, is needed to make a decision*
 *- Please use the FOH Medical Surveillance Health History and Physical Evaluation forms for this
- 2. The following additional information is needed for review (specify what):

C. The employee is not given medical clearance for respirator use because of the health problems as noted below (choose one below)

- 1. A temporary health problem (which should be reevaluated in _____ months)
- 2. A health problem that appears permanent (routine re-evaluation is not needed)

 Examiner / Reviewer Name (Print)

 Phone number for questions

 Examiner / Reviewer Signature

 Date:

Print Health Center Stamp above