Respirator Medical Evaluation

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

To the employer: Answer to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

Today's date: _____

Your name: _____ Date of Birth:_____/_____/_____

Your age:_____

Sex (circle one): MALE / FEMALE

Your height: _____ feet _____ inches Your Weight: _____ lbs.

Job Title_____

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 (circle one): YES / NO

Check the type of respirator you will use (You can check more than on category):

_____ N, R, or P disposable respirator (filter-mask, non-cartridge type only)

_____ Other type (for example, half, or full-face piece type, powered-air purifying, supplied-air, self contained breathing apparatus).

Have you worn a respirator (circle one): YES / NO

If "yes" what type(s):_____

Patient Name (PRINT):_____ **Date of Birth:** _____

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 circle "yes" or "no").*

1. Have you ever had any of the following conditions?

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

2. Do you currently smoke tobacco, or have you smoked tobacco in the last month?

YES	NO

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

	YES	NO
Asbestosis		
Asthma		
Chronic bronchitis		
Emphysema		
Pneumonia		
Tuberculosis		
Silicosis		
Pneumothorax (collapsed lung)		
Lung Cancer		
Broken ribs		
Any chest injuries or surgeries		
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
Shortness of breath		
Shortness of breath when walking fast on level ground or walking up a slight hill/incline		
Shortness of breath when walking with other people at an ordinary pace on level ground		
Have to stop for breath when walking at your own pace on level ground		
Shortness of breath when washing or dressing yourself		
Shortness of breath that interferes with your job		
Coughing that produces phlegm (thick sputum)		
Coughing that waked you early in the morning		
Coughing that occurs mostly when you are lying down		
Coughing up blood in the last month		
Wheezing		
Wheezing that interferes with your job		
Chest pain when you breathe deeply		
Any other symptoms that you think may be related to lung problems		

Patient Name (PRINT):_____ **Date of Birth:** _____

5. Have you ever had any of the following cardiovascular or heart problems?

	YES	NO
Heart Attack		
Stroke		
Angina		
Heart Failure		
Swelling in your legs or feet (not caused by walking)		
Heart arrhythmia (heart beating irregularly)		
High blood pressure		
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
Frequent pain or tightness in your chest		
Pain or tightness in your chest during physical activity		
Pain or tightness in your chest that interferes with your job		
In the past two years, have you noticed your heart skipping or missing a beat		
Heartburn or indigestion that is not related to eating		
Any other symptoms that your think may be related to heart or circulation problems		

7. Do your currently take medication for any of the following problems?

	YES	NO
Breathing or lung		
Heart trouble		
Blood Pressure		
Seizures		

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); _____

	YES	NO
Eye irritation		
Skin allergies or rashes		
Anxiety		
General weakness or fatigue		
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

Patient Name (PRINT):_____ **Date of Birth:** _____

Questions 10 to 15: below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types or 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
Wear contact lenses		
Wear glasses		
Color blind		
Any other eye or vision problems		

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?

	YES	NO
Difficulty hearing		
Wear a hearing aid		
Any other hearing or ear problems		

14. Have you ever had a back injury: YES / NO

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

	YES	NO
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		

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

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 contact with hazardous chemicals:** YES / NO

   If "yes" name the chemicals if you know them:_____

Patient Name (PRINT):_____ **Date of Birth:** _____

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

	YES	NO
Asbestos		
Silica (**e.g.,** in sandblasting)		
Tungsten/cobalt (e.g., grinding or welding this materials		
Beryllium		
Aluminum		
Coal (for example, mining)		
Iron		
Tin		
Dusty environments		
Any other hazardous exposures		

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 trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medication for any reason (including over-the-counter medications):** YES / NO

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

	YES	NO
HEPA Filters		
Canisters (for example, gas masks)		
Cartridges		

11. **How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you?**

	YES	NO
Escape only		
Emergency rescue only		
Less than 5 hours **per week**		
Less than 2 hours **per day**		
2 to 4 hours per day		
Over 4 hours per day		

12. **During the period you are using the respirator(s), is your work effort:**

	YES	NO
Light (less than 200 kcal per hour)		

If "yes" how long does this period last during the average shift:_____ hour's _____ minutes
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.

	YES	NO
Moderate (200 to 350 kcal per hour)		

If "yes" how long does this period last during the average shift:_____ hour's _____ minutes
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.

	YES	NO
Heavy (above 350 kcal per hour)		

If "yes" how long does this period last during the average shift:_____ hour's _____ minutes
Example 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 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 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 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):