Respirator Medical Evaluation Questionnaire
OSHA 29CFR 1910.134

Employee Name (Print): _____ Employee Number: _____

Employee Signature: _____ Date: _____

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? (circle 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 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).

1. Today's date: _____ / ____ / ____

2. Your name: _____

3. Your age (to nearest year): _____

4. Sex (circle one): Male / Female

5. Your height: _____ ft. _____ in.

6. Your weight: _____ lbs.

7. Your job title: _____

8. A phone where you can be reached by the health care professional who will review this questionnaire (include area code): ( ) _____

9. The best time to reach you at this phone number: _____ (circle one) a.m. / p.m.

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one) Yes / No PLHCP:

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

12. Have you worn a respirator (circle one): Yes / No

13. If "yes" list 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 circle "Yes" or "No").

1. Do you currently smoke tobacco, or have you smoked in the last month?: Yes / No

2. Have you ever had any of the following conditions? (If yes, when was your last event, or episode?)

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 places): Yes / No

e. Trouble smelling odors: Yes / No

3. Have you ever had any of the following pulmonary or lung problems? (If yes, when was your last event, or episode?)

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've been told about by a medical doctor: 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 at a normal pace up a slightly elevated 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 up 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 you 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? Yes / No

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 associated with walking)? Yes / No

f. Heart arrhythmia (irregular heart beat)? Yes / No

g. High blood pressure? Yes / No

6. Any other heart problems that you've been told about by a medical doctor? Yes / No

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

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 appear to skip or miss 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

8. Do you currently take any medication prescribed by a medical doctor for any of the following problems?

a. Breathing or lung problems? Yes / No

b. Heart trouble? Yes / No

c. Seizures? Yes / No

9. If you've used a respirator, have you ever had any of the following problems? (If you never used a respirator, skip this section and go to question 10)

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 your use of a respirator? Yes / No

f. 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 to 15 below, must be answered by every employee who has been selected 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?

    a. Wear contact lenses? Yes / No

    b. Wear glasses? Yes / No

    c. Color blind? Yes / No

    d. Any other eye or vision problems? Yes / No

12. Have you ever had an injury to your ears, including broken ear drum? Yes / No

13. Do you currently have any of the following hearing problems?

    a. Difficulty hearing? Yes / No

    b. Wear a hearing aid(s)? Yes / No

    c. Any other hearing or eardrum problem? Yes / No

14. Have you ever had a back injury for which you received medical treatment? Yes / No

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

    a. Weakness in any of your arms, hands, legs, or feet? Yes / No

    b. Back pain? Yes / No

    c. Difficulty moving your arms or legs? Yes / No

    d. Pain or stiffness when you lean forward or backward at the waist? Yes / No

    e. Difficulty moving your head up or down? Yes / No

    f. Difficulty moving your head side-to-side? Yes / No

    g. Difficulty bending at your knees? Yes / No

    h. Difficulty squatting to the ground? Yes / No

    i. Climbing a ladder or flight of stairs carrying more than 25 pounds? Yes / No

    j. Any other muscle or skeletal problems that interferes with using a respirator? Yes / No