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

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 (check 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).

1. Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Your name: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Sex (check one) 🞎 Male 🞎Female
5. Your height: \_\_\_\_\_ft. \_\_\_\_\_\_\_in.
6. Your weight: \_\_\_\_\_ lbs.
7. Your job title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the area code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. The best time to phone you at this number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. Has your employer told you how to contact the health care professional who will review this questionnaire (check one): 🞎 Yes 🞎 No
11. Check the type of respirator you will use (you can check more than one category):
	1. 🞎 N, R, or P disposable respirator (filter mask, non-cartridge type only)
	2. 🞎 Other type (for example, half- or full- face piece type, powered-air purifying, suppled air, self-contained breathing apparatus).
12. Have you worn a respirator (check one): 🞎 Yes 🞎 No

If “yes”, what type (s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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?
	1. Seizures (fits): 🞎 Yes 🞎 No
	2. Diabetes (sugar disease): 🞎 Yes 🞎No
	3. Allergic reactions that interfere with your breathing: 🞎 Yes 🞎No
	4. Claustrophobia (fear in closed-in places): 🞎 Yes 🞎No
	5. Trouble smelling odors: 🞎 Yes 🞎No
3. Have you ever had any of the following pulmonary or lung problems?
	1. Asbestosis: 🞎 Yes 🞎No
	2. Asthma: 🞎 Yes 🞎No
	3. Chronic bronchitis: 🞎 Yes 🞎No
	4. Emphysema: 🞎 Yes 🞎No
	5. Pneumonia: 🞎 Yes 🞎No
	6. Tuberculosis: 🞎 Yes 🞎No
	7. Silicosis: 🞎 Yes 🞎No
	8. Pneumothorax (collapsed lung): 🞎 Yes 🞎No
	9. Lung cancer: 🞎 Yes 🞎No
	10. Broken ribs: 🞎 Yes 🞎No
	11. Any chest injuries or surgeries: 🞎 Yes 🞎No
	12. Any other lung problems that you’ve been told about: 🞎 Yes 🞎No
4. Do you currently have any of the following symptoms of pulmonary or lung illness?
	1. Shortness of breath: 🞎 Yes 🞎No
	2. Shortness of breath when walking fast on level ground or walking up a

hill or incline: 🞎 Yes 🞎No

* 1. Shortness of breath when walking with other people at an ordinary

pace on level ground: 🞎 Yes 🞎No

* 1. Have to stop for breath when walking at your own pace on

on level ground: 🞎 Yes 🞎No

* 1. Shortness of breath when washing or dressing yourself: 🞎 Yes 🞎No
	2. Shortness of breath that interferes with your job: 🞎 Yes 🞎No
	3. Coughing that produces phlegm (thick sputum): 🞎 Yes 🞎No
	4. Coughing that wakes you early in the morning: 🞎 Yes 🞎No
	5. Coughing that occurs mostly when you are lying down: 🞎 Yes 🞎No
	6. Coughing up blood in the last month: 🞎 Yes 🞎No
	7. Wheezing: 🞎 Yes 🞎No
	8. Wheezing that interferes with your job: 🞎 Yes 🞎No
	9. Chest pain when you breathe deeply: 🞎 Yes 🞎No
	10. Any other symptoms that you think may be related to lung problems: 🞎 Yes 🞎No
1. Have you ever had any of the following cardiovascular or heart problems?
	1. Heart attack: 🞎 Yes 🞎No
	2. Stroke: 🞎 Yes 🞎No
	3. Angina: 🞎 Yes 🞎No
	4. Heart failure: 🞎 Yes 🞎No
	5. Swelling in your legs or feet (not caused by walking): 🞎 Yes 🞎No
	6. Heart arrhythmia (heart beating irregularly) 🞎 Yes 🞎No
	7. High blood pressure: 🞎 Yes 🞎No
	8. Any other heart problem that you’ve been told about: 🞎 Yes 🞎No
2. Have you ever had any of the following cardiovascular or heart symptoms?
	1. Frequent pain or tightness in your chest: 🞎 Yes 🞎No
	2. Pain or tightness in your chest during physical activity: 🞎 Yes 🞎No
	3. Pain or tightness in your chest that interferes with your job: 🞎 Yes 🞎No
	4. In the past two years, have you noticed your heart skipping or

or missing a beat: 🞎 Yes 🞎No

* 1. Heartburn or indigestion that is not related to eating: 🞎 Yes 🞎No
	2. Any other symptoms that you think may be related to heart or

circulation problems: 🞎 Yes 🞎No

1. Do you currently take medication for any of the following problems? 🞎 Yes 🞎No
	1. Breathing or lung problems: 🞎 Yes 🞎No
	2. Heart trouble: 🞎 Yes 🞎No
	3. Blood pressure: 🞎 Yes 🞎No
	4. Seizures (fits): 🞎 Yes 🞎No
2. 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 the question 9): \_\_\_\_\_\_\_

* 1. Eye irritation 🞎 Yes 🞎No
	2. Skin allergies or rashes: 🞎 Yes 🞎No
	3. Anxiety: 🞎 Yes 🞎No
	4. General weakness or fatigue: 🞎 Yes 🞎No
	5. Any other problem that interferes with your use of a respirator: 🞎 Yes 🞎No
1. Would you like to talk to the health care professional who will review this questionnaire, about your answers to this questionnaire: 🞎 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 this questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has a lower-than-normal amount of oxygen? 🞎 Yes 🞎No

If YES, do you have feelings of dizziness, shortness of breath, pounding in your chest or other symptoms when you are working under these conditions? 🞎 Yes 🞎No

1. 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:

1. Have you ever worked with any of the materials, or under any of the conditions, listed below?
2. Asbestos 🞎 Yes 🞎No
3. Silica (e.g., sandblasting) 🞎 Yes 🞎No
4. Tungsten/cobalt (e.g., grinding or welding this material) 🞎 Yes 🞎No
5. Beryllium 🞎 Yes 🞎No
6. Aluminum 🞎 Yes 🞎No
7. Coal (i.e., mining) 🞎 Yes 🞎No
8. Iron 🞎 Yes 🞎No
9. Tin 🞎 Yes 🞎No
10. Dusty environments 🞎 Yes 🞎No
11. Any other hazardous exposures 🞎 Yes 🞎No

If YES, describe these exposures:

1. List any second jobs or side businesses you have:
2. List your previous occupations:
3. List your current or previous hobbies:
4. Have you ever been in the military services? 🞎 Yes 🞎No

If YES, were you exposed to biological or chemical

agents (either in training or combat)? 🞎 Yes 🞎No

1. Have you ever worked on a HAZMAT team? 🞎 Yes 🞎No
2. 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:

1. Will you be using any of the following items with your respirator? 🞎 Yes 🞎No
2. HEPA filters 🞎 Yes 🞎No
3. Canister (i.e., gas masks) 🞎 Yes 🞎No
4. Cartridges 🞎 Yes 🞎No
5. How often are you expected to use the respirator(s)? (Check YES or NO for all answers that apply to you)
6. Escape only (no rescue) 🞎 Yes 🞎No
7. Emergency rescues only 🞎 Yes 🞎No
8. Less than five hours per week 🞎 Yes 🞎No
9. Less than two hours per week 🞎 Yes 🞎No
10. Two to four hours per day 🞎 Yes 🞎No
11. Over four hours per day 🞎 Yes 🞎No
12. During the period that you are using the respirator(s), is your work effort:
	1. Light (less than 200kcal per hour) 🞎 Yes 🞎No

If YES, how long does this period last during the average shift:

\_\_\_\_\_\_\_\_\_hours \_\_\_\_\_\_\_\_\_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

* 1. Moderate (200 to 350 kcal per hour) 🞎 Yes 🞎No

If YES, how long does this period last during the average shift?

\_\_\_\_\_\_\_\_hours \_\_\_\_\_\_\_\_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 assemble work, or transferring a moderate load (about 35 lbs) at a trunk level; walking on a level surface about 2mph or down a 5° grade about 3mph; or pushing a wheelbarrow with a heavy load (about 100 lbs) on a level surface.

* 1. Heavy (about 350 kcal) 🞎 Yes 🞎No

If YES, how long does this period last during the average shift?

\_\_\_\_\_\_\_hours \_\_\_\_\_\_\_\_minutes

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° grade about 2mph; climbing stairs with a heavy load (about 50 lbs).

If YES, how long does this period last during the average shift?

\_\_\_\_\_\_\_hours \_\_\_\_\_\_\_\_minutes

1. Will you be wearing protective clothing and/or equipment (other than the respirator) when you are using your respirator? 🞎 Yes 🞎No
2. Will you be working under hot conditions (temperature exceeding 77°F)? 🞎 Yes 🞎No
3. Will you be working under humid conditions? 🞎 Yes 🞎No
4. Describe the work you will be doing while you are using your respirator(s):
5. Describe any special or hazardous conditions you might encounter when you are using your respirator(s) (i.e., confined spaces, life-threatening gases):
6. Provide the following information, if you know it, for each toxic substance that you will be exposed to when you are using your respirator(s):

Name of the 1st toxic substance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Estimate the maximum exposure level per shift: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the 2nd toxic substance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Estimate the maximum exposure level per shift: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the 3rd toxic substance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Estimate the maximum exposure level per shift: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The name of any other toxic substance that you will be exposed to while using your respirator(s):

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