WORKSITE+WELLNESS
OCCUPATIONAL HEALTH SERVICES,LLC

Appendix C of 29 CFR Section 1910.134
OSHA Respirator Medical Evaluation Questionnaire

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: 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: First_____Last_____

3. Your age (to nearest year):_____

4. Sex: _____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:_____AM_____Daytime_____PM_____Any

10. Has your employer told you how to contact the health care professional who will review this questionnaire:_____Yes _____No

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-facepiece type, powered-air purifying,supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator:_____Yes _____No

    If "yes," what type(s):_____

Name: **DOB:**

WORKSITE+WELLNESS
OCCUPATIONAL HEALTH SERVICES,LLC

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 answer "yes" or "no").

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

_____Y _____N If yes, how much do you smoke per day?_____

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

_____Y _____N a. Seizures

_____Y _____N b. Diabetes (sugar disease)

_____Y _____N c. Allergic reactions that interfere with your breathing

_____Y _____N d. Claustrophobia (fear of closed-in places)

_____Y _____N e. Trouble smelling odors

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

_____Y _____N a. Asbestosis

_____Y _____N b. Asthma

_____Y _____N c. Chronic bronchitis

_____Y _____N d. Emphysema

_____Y _____N e. Pneumonia

_____Y _____N f. Tuberculosis

_____Y _____N g. Silicosis

_____Y _____N h. Pneumothorax (collapsed lung)

_____Y _____N i. Lung cancer

_____Y _____N j. Broken ribs

_____Y _____N k. Any chest injuries or surgeries

_____Y _____N l. 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?

_____Y _____N a. Shortness of breath (SOB)

_____Y _____N b. SOB when walking fast on level ground or walking up a hill or incline

_____Y _____N c. SOB when walking with other people at an ordinary pace on level ground

_____Y _____N d. Have to stop for breath when walking at your own pace on level ground

_____Y _____N e. SOB when washing or dressing yourself

_____Y _____N f. SOB that interferes with your job

_____Y _____N g. Coughing that produces phlegm (thick sputum)

_____Y _____N h. Coughing that wakes you early in the morning

_____Y _____N i. Coughing that occurs mostly when you are lying down

_____Y _____N k. Wheezing

WORKSITE+WELLNESS
OCCUPATIONAL HEALTH SERVICES,LLC

_____Y _____N l. Wheezing that interferes with your job

_____Y _____N m. Chest pain when you breathe deeply

_____Y _____N n. Any other symptoms that you think may be related to lung problems

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

_____Y _____N a. Heart attack

_____Y _____N b. Stroke

_____Y _____N c. Angina

_____Y _____N d. Heart failure

_____Y _____N e. Swelling in your legs or feet (not caused by walking)

_____Y _____N f. Heart arrhythmia (heart beating irregularly)

_____Y _____N g. High blood pressure

_____Y _____N h. Any other heart problem that you've been told about

6. Have you ever had any of the following cardiovascular or heart symptoms?

_____Y _____N a. Frequent pain or tightness in your chest

_____Y _____N b. Pain or tightness in your chest during physical activity

_____Y _____N c. Pain or tightness in your chest that interferes with your job

_____Y _____N d. In the past two years, have you noticed your heart skipping or missing a beat

_____Y _____N e. Heartburn or indigestion that is not related to eating

_____Y _____N f. Any other symptoms that you think may be related to heart or circulation problems

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

_____Y _____N a. Breathing or lung problems

_____Y _____N b. Heart trouble

_____Y _____N c. Blood pressure

_____Y _____N d. 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.)

_____Y _____N a. Eye irritation

_____Y _____N b. Skin allergies or rashes

_____Y _____N c. Anxiety

_____Y _____N d. General weakness or fatigue

_____Y _____N e. 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?

_____Y _____N

WORKSITE+WELLNESS
OCCUPATIONAL HEALTH SERVICES,LLC

Questions 10 to 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)?

_____Y _____N

11. Do you currently have any of the following vision problems?

_____Y _____N a. Wear contact lenses

_____Y _____N b. Wear glasses

_____Y _____N c. Color blind

_____Y _____N d. Any other eye or vision problem

12. Have you ever had an injury to your ears, including a broken eardrum?

_____Y _____N

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

_____Y _____N a. Difficulty hearing

_____Y _____N b. Wear a hearing aid

_____Y _____N c. Any other hearing or ear problem

14. Have you ever had a back injury?

_____Y _____N

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

_____Y _____N a. Weakness in any of your arms, hands, legs, or feet

_____Y _____N b. Back pain

_____Y _____N c. Difficulty fully moving your arms and legs

_____Y _____N d. Pain and stiffness when you lean forward or backward at the waist

_____Y _____N e. Difficulty fully moving your head up or down

_____Y _____N f. Difficulty fully moving your head side to side

_____Y _____N g. Difficulty bending at your knees

_____Y _____N h. Difficulty squatting to the ground

_____Y _____N i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.

_____Y _____N j. Any other muscle or skeletal problem that interferes with using a respirator