The Smarter Choice for Care
Middlesex Health
Occupational + Environmental Medicine

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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:
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: _____ Date of Birth: _____
3.) Your Age (to nearest year):_____ 4.) Sex (circle one): Male or 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/pm (circle one)
10.) Has your employer told you how to contact the health care professional who will review this questionnaire (circle one)Yes or 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 (circle one): Yes or 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 circle "yes" or "no"). **If you answer "yes" to any question, please explain in the "Comments" section on the final page.**

1.) Do you *currently* smoke tobacco, or have you smoked tobacco in the last month: Yes or No		
2.) Have you *ever had* any of the following conditions?		
a. Seizures:	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?		
a. Asbestosis:	Yes	No
b. Asthma:	Yes	No
c. Sleep Apnea	Yes	No
d. Chronic bronchitis:	Yes	No
e. Emphysema:	Yes	No
f. Pneumonia:	Yes	No
g. Tuberculosis:	Yes	No
h. Silicosis	Yes	No
i. Pneumothorax (collapsed lung):	Yes	No
j. Lung cancer:	Yes	No
k. Broken ribs:	Yes	No
l. Any chest injuries or surgeries:	Yes	No
m. Any other lung problem that you've been told about:	Yes	No

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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 up a slight 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 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 your 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?		
a. Heartattack:	Yes	No
b. Stroke:	Yes	No
c. Angina:	Yes	No
d. Heartfailure:	Yes	No
e. Swelling in your legs or feet (not caused by walking):	Yes	No
f. Heart arrhythmia (heart beating irregularly):	Yes	No
g. High blood pressure:	Yes	No
h. 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?		
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 skipping or missing a beat:	Yes	No
e. Heartburn or indigestion that is not related to eating:	Yes	No
d. 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?		
a. Breathing or lung problems:	Yes	No
b. Hearttrouble:	Yes	No
c. Bloodpressure:	Yes	No
d. Seizures:	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.):		
a. Eyeirritation:	Yes	No
b. Skin allergies or rashes:	Yes	No
c. Anxiety:	Yes	No
d. General weakness or fatigue:	Yes	No
e. Any other problem that interferes with your use of a respirator:	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 or No		

Questions10 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.

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10.) Have you *ever lost* vision in either eye (temporarily or permanently)? Yes or No		
11.) Do you *currently* have any of the following vision problems?		
a. Wear contact lenses:	Yes	No
b. Wear glasses:	Yes	No
c. Colorblind:	Yes	No
d. Any other eye or vision problem:	Yes	No
12.) Have you *ever had* an injury to your ears, including a broken ear drum? Yes or No		
13.) Do you *currently* have any of the following hearing problems?		
a. Difficulty hearing:	Yes	No
b. Wear a hearing aid:	Yes	No
c. Any other hearing or ear problem:	Yes	No
14.) Have you *ever had* a back injury: Yes or 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 fully moving your arms and legs:	Yes	No
d. Pain or stiffness when you lean forward or backward at the waist:	Yes	No
e. Difficulty fully moving your head up or down:	Yes	No
f. Difficulty fully 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 flight of stairs or a ladder carrying more than 25 lbs:	Yes	No
j. Any other muscle or skeletal problem that interferes with using a respirator:	Yes	No

Comments for any "Yes" responses. Please also include the question number that your comments refer to:
