

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 (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 healthcare 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 number where you can be reached by the healthcare 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 healthcare professional who will review this questionnaire (circle one)?
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 (circle one)? Yes/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).

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?
 - 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?
 - 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 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 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. 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 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
 - f. 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?
- c. Breathing or lung problems Yes/No
 - d. Heart trouble Yes/No
 - e. Blood pressure Yes/No
 - f. Seizures (fits) 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. 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 problem that interferes with your use of a respirator Yes/No
9. Would you like to talk to the healthcare 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-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)? 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 problem Yes/No
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?
- 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/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

Part B. Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the healthcare 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

If yes, do you have feelings of dizziness, shortness of breath, pounding in your chest or other symptoms when you're working under these conditions? 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 skin contact with hazardous chemicals? Yes/No

If yes, name the chemicals if you know them _____

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

- a. Asbestos Yes/No
- b. Silica (e.g., in sandblasting) Yes/No
- c. Tungsten/cobalt (e.g., grinding or welding this material) Yes/No
- d. Beryllium Yes/No
- e. Aluminum Yes/No
- f. Coal (for example, mining) Yes/No
- g. Iron Yes/No
- h. Tin Yes/No
- i. Dusty environments Yes/No
- j. Any other hazardous exposures Yes/No

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 medications for any reason (including over-the-counter medications)? Yes/No

If yes, name the medications if you know them _____

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

- a. HEPA filters Yes/No
- b. Canisters (for example, gas masks) Yes/No
- c. Cartridges Yes/No

11. How often are you expected to use the respirator(s) (circle Yes or No for all answers that apply to you)?

- a. Escape only (no rescue) Yes/No
- b. Emergency rescue only Yes/No
- c. Less than 5 hours per week Yes/No
- d. Less than 2 hours per day Yes/No
- e. 2 to 4 hours per day Yes/No
- f. Over 4 hours per day Yes/No

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

Light (less than 200 kcal per hour)? Yes/No

If yes, how long does this period last during the average shift _____hrs. _____mins.

Examples of a light work effort are sitting while writing, typing, drafting or performing light assembly work; or standing while operating a drill press (one to three pounds) or controlling machines.

Moderate (200 to 350 kcal per hour)? Yes/No

If yes, how long does this period last during the average shift _____hrs. _____mins.

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 pounds) at trunk level; walking on a level surface about two mph or down a five-degree grade about three mph; or pushing a wheelbarrow with a heavy load (about 100 pounds) on a level surface.

Heavy (above 350 kcal per hour)? Yes/No

If yes, how long does this period last during the average shift _____hrs. _____mins.

Examples of heavy work are lifting a heavy load (about 50 pounds) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an eight-degree grade about two mph; climbing stairs with a heavy load (about 50 pounds).

13. Will you be wearing protective clothing and/or equipment (other than the 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° F)? Yes/No

15. Will you be working under humid conditions? Yes/No

16. Describe the work you'll be doing while 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 you'll be exposed to when 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 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)

