OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

Appendix C to Sec. 1910.134:

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.

Can you read? (circle one)	Yes	No
Name of employer/fire district:		

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. Name :			
3. Age (to the nearest year):	4. Sex (circle one):	Female	Male
5. Height: _____ ft _____ in	6. Weight: _____ lbs.		

7. FF/EMS duties: (circle if applicable)	Interior FF	Exterior FF	Fire Police	EMS	Other:
a. What is your "day job"/job title?					
b. Number of years on this job:					

8. What is a phone number where you can be reached by the healthcare professional who reviews this questionnaire? (Include area code)		
9. The best time to reach you at this number:		
10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one):	Yes	No

11. Check the type of respirator you will use (you can circle more than one category):		
N, R, or P disposable respirator (filter-mask, non-cartridge type only).		
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
a. 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"). Please explain any yes answers in comment section on page 4.

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	Yes	No
e. Trouble smelling odors	Yes	No

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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. Heartburn or indigestion that is not related to eating:					Yes	No
7. Do you currently take medication for any of the following problems?						
a. Breathing or lung problems:					Yes	No
b. Heart trouble:					Yes	No
c. Blood pressure:					Yes	No
d. Seizures:					Yes	No

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8. If you have 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 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-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/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. Wearing a hearing aid:	Yes	No
c. Any other hearing 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. Please complete the following information regarding your chemical exposures, personal protective equipment use, and previous employment.

1. Please list your past jobs below		
Dates	Job Title & Description	Protective Equipment Used at Job

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2. Have you ever worked at a job or had a hobby in which you came into contact with any of the following by breathing, touching, or ingestion (swallowing)? If yes, please check the box beside the name.

- □ Acids
- □ Airborne Pathogens
- □ Alcohols (industrial)
- □ Alkalies
- □ Ammonia
- □ Arsenic
- □ Asbestos
- □ Benzene
- □ Beryllium
- □ Bloodborne Pathogens
- □ Cadmium
- □ Carbon tetrachloride
- □ Chlorinated naphthalenes
- □ Chloroform
- □ Chloroprene
- □ Chromates
- □ Coal dust
- □ Dichlorobenzene
- □ Ethylene dibromide
- □ Ethylene dichloride
- □ Fiberglass
- □ Formaldehyde
- □ Halothane
- □ Isocyanates
- □ Ketones
- □ Lead
- □ Manganese
- □ Mercury
- □ Methylene chloride
- □ Nickel
- □ Organic Dust
- □ PPBs
- □ PCBs
- □ Perchloroethylene
- □ Pesticides
- □ Phenol
- □ Phosgene
- □ Radiation
- □ Rock dust
- □ Silica powder
- □ Silo Gas
- □ Solvents
- □ Styrene
- □ Talc
- □ Toluene
- □ TDI or MDI
- □ Trichloroethylene
- □ Trinitrotoluene
- □ Vinyl chloride
- □ Welding fumes
- □ X-rays
- □ Loud noises
- □ Other (specify): _____
- □ Typical fire exposures including: fumes, particulate aldehydes, carbon monoxide, carbon dioxide, nitrogen dioxide, hydrogen chloride, hydrogen cyanide acrolein, vol. organic compounds

Comments:

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