## OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE
## 1910.134 Appendix C (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? ❑ 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 whop will review it.*

**Part A. Section 1. (Mandatory)**

Date: ___/___/___ Employee Number: _____

Name: _____ Age: _____

Job Title: _____ Height: _____ft. ____in.

Weight: _____lbs.

Phone number where you can be reached by the Health Care Professional who reviews this questionnaire (including Area Code): _____ Best time to reach you at this number: _____ days

Has your employer told you how to contact the health care professional who will review this questionnaire?
❑ Yes ❑ No

Check the type of respirator you will use (you can check more than one category):

☑ N, R, or P disposable respirator (filter-mask, non-cartridge type only) **N95**

❑ Other type (for example, half – or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus

Have you ever worn a respirator? ❑ Yes ❑ No If yes, what type(s): _____

**Part A. Section 2. (Mandatory)**

| | | |
|---|---|---|
| **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 | ❑ 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 problems 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 in an ordinary place | ❑ Yes | ❑ No |
| d. Have to stop for breath when walking at your own pace on ground level | ❑ 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 up 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 problem?**

| | | |
|---|---|---|
| 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 problems 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?**

| | | |
|---|---|---|
| a. Breathing or lung problems | ❑ Yes | ❑ No |
| b. Heart trouble | ❑ Yes | ❑ No |
| c. Blood pressure | ❑ Yes | ❑ No |
| d. Seizures (fits) | ❑ Yes | ❑ No |

**8. If you've used a respirator, have you ever had any of the following problems? (If you've never had used a respirator, check the following box ❑ 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 problems 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