

**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 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).

		Comments	Yes	No
	Name: _____			
3.	Age (to nearest year): _____			
4.	Sex (circle one): _____	Male / Female		
5.	Height (feet' inches"): _____			
6.	Weight (pounds): _____			
8.	A phone number where you can be reached by the health care professional who reviews this questionnaire (including Area Code): _____			
9.	The best time to phone you at this number (a.m. or p.m.): _____			
10.	Has your employer told you how to contact the health care professional who will review this questionnaire?		_____	_____
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).	N, R, or P		
b.	Other type (for example half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus). _____			
12.	Have you worn a respirator?			

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 check "yes" or "no").

		Comments	Yes	No	
1.	Do you currently smoke tobacco, or have you smoked tobacco in the last month?		_____	_____	
2.	Have you ever had any of the following conditions?				
a.	Seizures (fits):		_____	_____	
b.	Diabetes (sugar disease):		_____	_____	
c.	Allergic reactions that interfere with your breathing:		_____	_____	
d.	Claustrophobia (fear of closed-in places):		_____	_____	
e.	Trouble smelling odors:		_____	_____	
3.	Have you ever had any of the following pulmonary or lung problems?				
		Yes	No	Yes	No
a.	Asbestosis:	_____	_____	_____	_____
b.	Asthma:	_____	_____	_____	_____
c.	Chronic bronchitis:	_____	_____	_____	_____
d.	Emphysema:	_____	_____	_____	_____
e.	Pneumonia:	_____	_____	_____	_____
f.	Tuberculosis:	_____	_____	_____	_____
g.	Silicosis:	_____	_____	_____	_____
h.	Pneumothorax (collapsed lung):	_____	_____	_____	_____
i.	Lung cancer:	_____	_____	_____	_____
j.	Broken ribs:	_____	_____	_____	_____
k.	Any chest injuries or surgeries	_____	_____	_____	_____
l.	Any other lung problem that you've been told about:	_____	_____	_____	_____

		Comments	Yes	No
4.	Do you currently have any of the following symptoms of pulmonary or lung illness?		_____	_____
a.	Shortness of breath:		_____	_____
b.	Shortness of breath when walking fast on level ground or walking up a slight hill or incline:		_____	_____
c.	Shortness of breath when walking with other people at an ordinary pace on level ground:		_____	_____
d.	Have to stop for breath when walking at your own pace on level ground:		_____	_____
e.	Shortness of breath when washing or dressing yourself:		_____	_____
f.	Shortness of breath that interferes with your job:		_____	_____
g.	Coughing that produces phlegm (thick sputum):		_____	_____
h.	Coughing that wakes you early in the morning:		_____	_____
i.	Coughing that occurs mostly when you are lying down:		_____	_____
j.	Coughing up blood in the last month:		_____	_____
k.	Wheezing:		_____	_____
l.	Wheezing that interferes with your job:		_____	_____
m.	Chest pain when you breathe deeply:		_____	_____
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:			
a.	Heart attack:		_____	_____
b.	Stroke:		_____	_____
c.	Angina:		_____	_____
d.	Heart failure:		_____	_____
e.	Swelling in your legs or feet (not caused by walking):		_____	_____
f.	Heart arrhythmia (heart beating irregularly):		_____	_____
g.	High blood pressure:		_____	_____
h.	Any other heart problem that you've been told about:		_____	_____
6.	Have you ever had any of the following cardiovascular or heart symptoms?			
a.	Frequent pain or tightness in your chest:		_____	_____
b.	Pain or tightness in your chest during physical activity:		_____	_____
c.	Pain or tightness in your chest that interferes with your job:		_____	_____
d.	In the past two years, have you noticed your heart skipping or missing a beat:		_____	_____
e.	Heartburn or indigestion that is not related to eating:		_____	_____
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:			
a.	Breathing or lung problems:		_____	_____
b.	Heart trouble:		_____	_____
c.	Blood pressure:		_____	_____
d.	Seizures (fits):		_____	_____
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:		_____	_____
b.	Skin allergies or rashes:		_____	_____
c.	Anxiety:		_____	_____
d.	General weakness or fatigue:		_____	_____
e.	Any other problem that interferes with your use of a respirator:		_____	_____
9.	<i>Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire:</i>		_____	_____

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece 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.

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

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

		Comments	Yes	No			
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: 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:		_____	_____			
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: 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						
		Yes	No	Yes	No		
a.	Asbestos:	_____	_____	b.	Silica (sandblasting):	_____	_____
c.	Tungsten/cobalt (grinding or welding):	_____	_____	d.	Beryllium:	_____	_____
e.	Aluminum:	_____	_____	f.	Coal (mining):	_____	_____
g.	Iron:	_____	_____	h.	Tin:	_____	_____
i.	Dusty environments:	_____	_____	j.	Any other hazardous exposures	_____	_____
	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:						

	Comments	Yes	No
7.	Have you been in the military services? If "yes," were you exposed to biological or chemical agents (either in training or combat):	_____	_____
8.	Have you ever worked on a HAZMAT team?	_____	_____
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):	_____	_____
	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:	_____	_____
b.	Canisters (for example, gas masks):	_____	_____
c.	Cartridges:	_____	_____
11.	How often are you expected to use the respirator(s).		
	Yes                      No		
a.	Escape only (no rescue): _____	b.	Emergency rescue only: _____
c.	Less than 5 hours per week: _____	d.	Less than 2 hours per day: _____
e.	2 to 4 hours per day: _____	f.	Over 4 hours per day: _____
12.	During the period you are using the respirator(s), is your work effort:		
a.	Light (less than 200 kcal per hour):		
	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 (1-3 lbs.) or controlling machines.		
b.	Moderate (200 to 350 kcal per hour):		
	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 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.		
c.	Heavy (above 350 kcal per hour):		
	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 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).		
13.	Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator:	_____	_____
	If "yes," describe this protective clothing and/or equipment:		
14.	Will you be working under hot conditions (temperature exceeding 77 deg. F):	_____	_____
15.	Will you be working under humid conditions:	_____	_____
16.	Describe the work you'll be doing while you're 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 that you'll be exposed to when you're using your respirator(s):		
	Name of Toxic Substance	Estimated Maximum Exposed Level per Shift	Duration of Exposure per Shift
a.			
b.			
c.			
d.	The names of any other toxic substances you are exposed to while wearing a 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):		