

# OSHA Respirator Medical Evaluation Questionnaire

Regulations: Federal 1910.134, California Title 8:5144

**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). Check the appropriate answer.

Yes No

- Can you read?
1. Today's date: \_\_\_\_\_
  2. Name: \_\_\_\_\_
  3. Age: \_\_\_\_\_
  4. Sex: \_\_\_\_\_
  5. Height: \_\_\_\_\_ ft \_\_\_\_\_ in.
  6. Weight: \_\_\_\_\_ lbs.
  7. Job Title: \_\_\_\_\_
  8. 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: \_\_\_\_\_

Yes No 10. Has your employer told you how to contact the health care professional who will review this

questionnaire: *(For questions regarding this questionnaire, please call Employee Health)*

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 (check one): 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 check "yes" or "no").

Yes 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? If yes, please explain.

- 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:

Yes No 3. Have you ever had any of the following pulmonary or lung problems? If yes, please explain.

- 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:

**Yes No 4. Do you currently have any of the following symptoms of pulmonary or lung illness?**

**If yes, please explain.**

- 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:

**Yes No 5. Have you ever had any of the following cardiovascular or heart problems? If yes, please explain.**

- 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:

**Yes No 6. Have you ever had any of the following cardiovascular or heart symptoms? If yes, please explain.**

- 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:

**Yes No 7. Do you currently take medication for any of the following problems? If yes, please explain.**

- a.** Breathing or lung problems:
- b.** Heart trouble:
- c.** Blood pressure:
- d.** Seizures (fits):

**Yes No 8. If you've used a respirator, have you ever had any of the following problems? If yes, please Explain. (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:

**Yes No 9. Would you like to talk to the health care professional who will review this Questionnaire about?**

- your answers to this questionnaire?**