**APPENDIX B**

**SEC. 1910.134 OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (Mandatory)**

*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 heath care professional who will review it.*

|  |
| --- |
| Part A, Section 1 Mandatory, Employee Complete |

Can you read?  Yes  No

Date: Name: Age: Sex: Ht. Wt.

Daytime Phone: Best time to contact you

Job Title: Dept:

Has your employer told you how to contact the healthcare professional who will review this questionnaire?

Yes  No

Check the type of respirator you will use (You may check more than one).

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

Other type (for example, half-or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus). Describe:

Have you worn a respirator?  Yes  No

If yes, what type?

Do you currently have a beard or other facial hair?  Yes  No

|  |  |  |
| --- | --- | --- |
| Part A, Section 2, Mandatory Questions 1-9 for any Employee Selected to Use a Respirator | | |
|  | 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? |  |  |
| *If you have answered* ***Yes*** *to any above , please explain* | | |
| 3. Have you **ever had** any of the following pulmonary or lung problems? | | |
| 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? |  |  |
| *If you have answered* ***Yes*** *to any above, please explain* | | |
| Part A, Section 2 Mandatory Question 1-9 to any Employee Selected to Use a Respirator | | |
|  | 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 hampers 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? |  |  |
| *If you have answered* ***Yes*** *to any above, please explain* | | |
| 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 problems that you’ve been told about? |  |  |
| *If you have answered* ***Yes*** *to any above, please explain* | | |
| 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? |  |  |
| *If you have answered* ***Yes*** *to any above, please explain* | | |
| Part A, Section 2 Mandatory Question 1-9 to any Employee Selected to Use a Respirator | | |
|  | Yes | No |
| 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)? |  |  |
| *If you have answered Yes to any above, please explain* | | |
| 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? |  |  |
| *If you have answered* ***Yes*** *to any above, please explain* | | |
| 9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? | | |
|  |  |  |
| 10. I have answered these health questions accurately. | | |
|  |  |  |

Employee Signature: Date:

Based on review of OSHA Respirator Health Questionnaire this individual is:

Medically approved for all respirators, with the exceptions of SCBA, and subject to fit test

Not approved for respirator use at this time. Follow-up medical evaluation needed.

Reviewed By: Date:

Title:

7/20/2006