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## OSHA Respirator Medical Evaluation Questionnaire 29 CFR 1910.134

Can you read (circle one): Yes or 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 selected to use any type of respirator (please print).

1. Today's date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_
2. Last name: \_\_\_\_\_ First name: \_\_\_\_\_
3. Your Age: \_\_\_\_\_
4. Sex (circle one): Male or Female
5. Your height: \_\_\_\_\_ ft. \_\_\_\_\_ in.
6. Your Weight: \_\_\_\_\_ lbs.
7. Your job title: \_\_\_\_\_
8. A 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 reach you at this number: AM or PM
10. Has your employer told you how to contact the health care provider who will review this questionnaire (circle one): Yes or No
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, h~lf or full face-piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator (circle one): Yes or No  
If "yes," what type(s): \_\_\_\_\_

PLEASE TURN PAGE OVER AND CONTINUE ANSWERING THE QUESTIONS ON THE BACK,  
THANK YOU

**Part A. Section 2.** (MANDATORY) Questions 1 - 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "Yes" or "No").

1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month: Yes or No

2. Have you *ever had* any of the following conditions:

- a. Seizures (fits): Yes or No
- b. Diabetes (sugar disease): Yes or No
- c. Allergic reactions that interfere with your breathing: Yes or No
- d. Claustrophobia (fear of closed-in places): Yes or No
- e. Trouble smelling odors: Yes or No

3. Have you *eVer had* any of the following pulmonary or lung problems?

- a. Asbestosis: Yes or No
- b. Asthma: Yes or No
- c. Chronic bronchitis: Yes or No
- d. Emphysema: Yes or No
- e. Pneumonia: Yes or No
- f. Tuberculosis: Yes or No
- g. Silicosis: Yes or No
- h. Pneumothorax (collapsed lung): Yes or No
- i. Lung cancer: Yes or No
- j. Broken ribs: Yes or No
- k. Any chest injuries or surgeries: Yes or No
- l. Any other lung problem that you've been told about: Yes or No

If so what is the problem: \_\_\_\_\_

PLEASE GO TO NEXT PAGE AND ANSWER THE QUESTIONS, THANK YOU

**Continued, Part A. Section 2.** (MANDATORY) Questions below must be answered by every employee who has been selected to use any type of respirator (please circle "Yes" or "No").

4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?

- a. Shortness of breath: Yes or No
- b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes or No
- c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes or No
- d. Have to stop for breath when walking at your own pace on level ground: Yes or No
- e. Shortness of breath when washing or dressing yourself: Yes or No
- f. Shortness of breath that interferes with your job: Yes or No
- g. Coughing that produces phlegm (thick sputum): Yes or No
- h. Coughing that wakes you early in the morning: Yes or No
- i. Coughing that occurs mostly when you are lying down: Yes or No
- j. Coughing up blood in the last month: Yes or No
- k. Wheezing: Yes or No
- l. Wheezing that interferes with your job: Yes or No
- m. Chest pain when you breathe deeply: Yes or No
- n. Any other symptoms that you think may be related to lung problems: Yes or No

If so what symptoms: \_\_\_\_\_

5. Have you *ever had* any of the following cardiovascular or heart problems?

- a. Heart attack: Yes or No
- b. Stroke: Yes or No
- c. Angina: Yes or No
- d. Heart failure: Yes or No
- e. Swelling in your legs or feet (not caused by walking): Yes or No
- f. Heart arrhythmia (heart beating irregularly): Yes or No
- g. High blood pressure: Yes or No
- h. Any other heart problem that you have been told about: Yes or No

If so what: \_\_\_\_\_

PLEASE GO TO NEXT PAGE AND ANSWER THE QUESTIONS, THANK YOU

**Continued, Part A. Section 2.** (MANDATORY) Questions below must be answered by every employee who has been selected to use any type of respirator (please circle "Yes" or "No").

6. Have you *ever had* any of the following cardiovascular or heart symptoms:

- a. Frequent pain or tightness in your chest: Yes or No
- b. Pain or tightness in your chest during physical activity: Yes or No
- c. Pain or tightness in your chest that interferes with your job: Yes or No
- d. In the past two years, have you noticed your heart skipping or missing a beat:  
Yes or No
- e. Heartburn or indigestion that is not related to eating: Yes or No
- f. Any other symptoms that you think may be related to heart or circulation problems:  
Yes or No  
If so what symptoms: \_\_\_\_\_

7. Do you *currently* take medication for any of the following problems?

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

8. If you've used a respirator, have you *ever had* any of the following problems? If you've never used a respirator, skip this question and go to question 9:)

- a. Eye irritation: Yes or No
- b. Skin allergies or rashes: Yes or No
- c. Anxiety: Yes or No
- d. General weakness or fatigue: Yes or No
- e. Any other problem that interferes with your use of a respirator: Yes or No  
If so what problem: \_\_\_\_\_

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes or No

**Continued, Part A. Section 2.** (MANDATORY) Questions below must be answered by every employee who has been selected to use any type of respirator (please circle "Yes" or "No").

Are you being evaluated by a physician at the current time? Yes or No

If so, for what: \_\_\_\_\_

Have you had any of the following in the past six months? (please circle all that apply)

SURGERY Yes or No

CHEST PAIN Yes or No

INJURY Yes or No

DENTAL WORK Yes or No

SHORTNESS OF BREATH Yes or No

Do you have any of the following planned? (please circle all that apply)

SURGERY Yes or No

DENTAL WORK Yes or No

\_\_\_\_\_  
EMPLOYEE'S SIGNATURE

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY, STATE, ZIP CODE

\_\_\_\_\_  
PHONE NUMBER

\_\_\_\_\_  
NAME OF HEALTH CARE PROVIDER WHO REVIEWED FORM