Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

To the employer:
Answers to questions in Part A. Section 1, and to question 9 in Part A. Section 2, do not require a medical examination.

To the employee:
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).

1. Today's date: _____ 2. Your Name: _____

3. Date of Birth: _____ 4. Gender Identity: _____

5. Your height: _____ ft. _____ in. 6. Your Weight: _____

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 phone you at this number: _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): ☐ Yes No ☐

11. 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).
    - _____ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): ☐ Yes No ☐
    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 circle "yes" or "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?
    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 problem 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 at an ordinary pace on level ground: ☐ Yes ☐ No
   d. Have to stop for breath when walking at your own pace on level ground: ☐ 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 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 problems?
   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 problem 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: ☐ Yes ☐ No

8. If you've used a respirator, have you *ever had* any of the following problems? ☐ Yes ☐ No

9. (If you've never used a respirator, check “no” 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 problem that interferes with your use of a respirator: ☐ Yes ☐ No

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

Your Email:_____ Phone:_____

Return completed forms will be submitted to:

Bridget McCane-Saunders, Occupational Health

Specialist mailto:bmccane@binghamton.edu

607-237-3228