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Patient Label

OSHA RESPIRATORY FORM

## 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:**

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).**

**Today's Date:**_____/_____/_____

**Your name:**_____ **Employee #:**_____

**Your job title:**_____ **Sex:** ☐ **Male** ☐ **Female**

**Manager name:**_____ **Department:**_____ **Etx.**_____

**Your Age:**_____ **Telephone #: (**____**)**_____**-**_____

**Your Weight:**_____**kg** **Best time to reach you at above number:**

**Your Height:**_____**ft.**_____**in.** _____☐ **AM** ☐ **PM**

**Has your employer informed you on how to contact the health care professional who will review this questionnaire?** ☐ **Yes** ☐ **No**

**********

**Check the type of respirator you will use:** (*you may check more than one category*)

☐ **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: (please list)** _____

**Have you previously worn a respirator?** ☐ **Yes** ☐ **No**

**If yes, what type(s)?** _____

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**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.

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

**Please indicate "YES" or "NO" and explain all "YES" answers in the right hand column.**

| **2. Do you have now or ever had any of the below conditions?** | **YES** | **NO** | **EXPLAIN "YES" ANSWERS:** |
|---|---|---|---|
| Seizures | ☐ | ☐ | |
| Diabetes (sugar disease) | ☐ | ☐ | |
| Allergic reactions that interfere with your breathing | ☐ | ☐ | |
| Claustrophobia (fear of closed-in places) | ☐ | ☐ | |
| Trouble smelling odors (except with a cold) | ☐ | ☐ | |

| **3. Do you have now or ever had any of the below pulmonary or lung problems?** | **YES** | **NO** | **EXPLAIN "YES" ANSWERS:** |
|---|---|---|---|
| Asbestosis | ☐ | ☐ | |
| Asthma | ☐ | ☐ | |
| Chronic Bronchitis | ☐ | ☐ | |
| Emphysema/COPD | ☐ | ☐ | |
| Pneumonia | ☐ | ☐ | |
| Tuberculosis | ☐ | ☐ | |
| Silicosis | ☐ | ☐ | |
| Pneumothorax (collapsed lung) | ☐ | ☐ | |
| Lung cancer | ☐ | ☐ | |
| Broken ribs | ☐ | ☐ | |
| Any chest injuries or surgeries | ☐ | ☐ | |
| Any other lung problems you have been told about | ☐ | ☐ | |

| **4. Do you have now or ever had any of the below pulmonary or lung illness?** | **YES** | **NO** | **EXPLAIN "YES" ANSWERS:** |
|---|---|---|---|
| Shortness of breath | ☐ | ☐ | |
| Shortness of breath when walking fast on ground or walking up a slight hill or incline | ☐ | ☐ | |
| Shortness of breath when walking with other people at an ordinary pace on level ground | ☐ | ☐ | |
| Have to stop for breath when walking at your own pace on level ground | ☐ | ☐ | |

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**(Continued from page 2.)**

| **4. Do you have now or ever had any of the below pulmonary or lung illness?** | **YES** | **NO** | **EXPLAIN "YES" ANSWERS:** |
|---|---|---|---|
| Shortness of breath when washing or dressing | ☐ | ☐ | |
| Shortness of breath that interferes with your job | ☐ | ☐ | |
| Coughing that produces phlegm (thick sputum) | ☐ | ☐ | |
| Coughing that wakes you early in the morning | ☐ | ☐ | |
| Coughing that occurs mostly when you are lying down | ☐ | ☐ | |
| Coughing up blood in the last month | ☐ | ☐ | |
| Wheezing | ☐ | ☐ | |
| Wheezing that interferes with your job | ☐ | ☐ | |
| Chest pain when you breathe deeply | ☐ | ☐ | |
| 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?** | **YES** | **NO** | **EXPLAIN "YES" ANSWERS:** |
|---|---|---|---|
| Heart attack | ☐ | ☐ | |
| Stroke | ☐ | ☐ | |
| Angina | ☐ | ☐ | |
| Heart failure | ☐ | ☐ | |
| Swelling in your legs or feet (not caused by walking) | ☐ | ☐ | |
| Heart arrhythmia (heart beating irregularly) | ☐ | ☐ | |
| High blood pressure | ☐ | ☐ | |
| Any other heart problems you have been told about | ☐ | ☐ | |

| **6. Have you ever had any of the following cardiovascular or heart symptoms?** | **YES** | **NO** | **EXPLAIN "YES" ANSWERS:** |
|---|---|---|---|
| Frequent pain or tightness in your chest | ☐ | ☐ | |
| Pain or tightness in your chest during physical activity | ☐ | ☐ | |
| Pain or tightness in your chest that interferes with your job | ☐ | ☐ | |
| In the past two years, have you noticed your heart skipping or missing a beat | ☐ | ☐ | |
| Heartburn or indigestion that is not related to eating | ☐ | ☐ | |
| 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? | YES | NO | EXPLAIN "YES" ANSWERS: |
|---|---|---|---|
| Breathing or lung problems | ☐ | ☐ | |
| Heart trouble | ☐ | ☐ | |
| Blood pressure | ☐ | ☐ | |
| Seizures | ☐ | ☐ | |

| 8. If you have used a respirator, have you ever had any of the following problems? | YES | NO | EXPLAIN "YES" ANSWERS: |
|---|---|---|---|
| (If you have never used a respirator, check the following space and go to question 9.) ☐ never | | | |
| Eye irritation | ☐ | ☐ | |
| Skin allergies or rashes | ☐ | ☐ | |
| Anxiety | ☐ | ☐ | |
| General weakness or fatigue | ☐ | ☐ | |
| Any other problems that interfere with your use of a respirator | ☐ | ☐ | |

**9. Would you like to speak with the healthcare professional who will review this questionnaire about your answers to this questionnaire?** ☐ **Yes** ☐ **No**

**********

**ONLY COMPLETE SECTIONS BELOW FOR HALF FACE/ FULL FACE/ SCBA RESPIRATORS**

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

**PART A: SECTION 3.**

**10. Have you ever lost vision in either eye (temporarily or permanently)?** ☐ **Yes** ☐ **No**

| 11. Do you currently have any of these vision problems? | YES | NO | EXPLAIN "YES" ANSWERS: |
|---|---|---|---|
| Wear contact lenses | ☐ | ☐ | |
| Wear glasses | ☐ | ☐ | |
| Color blind | ☐ | ☐ | |
| Any other eye or vision problem | ☐ | ☐ | |

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**12. Have you ever had any injury to your ears, including a broken ear drum?** ☐ **Yes** ☐ **No**

| **13. Do you currently have any of these hearing problems?** | **YES** | **NO** | **EXPLAIN "YES" ANSWERS:** |
|---|---|---|---|
| Difficulty hearing | ☐ | ☐ | |
| Wearing a hearing aid | ☐ | ☐ | |
| Any other hearing or ear problem | ☐ | ☐ | |

**14. Have you ever had a back injury?** ☐ **Yes** ☐ **No**

| **15. Do you currently have any of the following musculoskeletal problems?** | **YES** | **NO** | **EXPLAIN "YES" ANSWERS:** |
|---|---|---|---|
| Weakness in any of your arms, hands, legs, or feet | ☐ | ☐ | |
| Back pain | ☐ | ☐ | |
| Difficulty fully moving your arms or legs | ☐ | ☐ | |
| Pain or stiffness when you lean forward or backwards at the waist | ☐ | ☐ | |
| Difficulty moving your head up or down | ☐ | ☐ | |
| Difficulty moving your head side to side | ☐ | ☐ | |
| Difficulty bending at your knees | ☐ | ☐ | |
| Difficulty squatting to the ground | ☐ | ☐ | |
| Climbing a flight of stairs or a ladder carrying more than 25 lbs. | ☐ | ☐ | |
| Any other muscle or skeletal problem that interferes with using a respirator | ☐ | ☐ | |

**********

**PART B: SECTION 1.: Complete this section (questions 1-19) if this the first OSHA Respiratory Questionnaire you have filled out for your employer. Otherwise fill this section out at the discretion of the health care provider.**

**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?** ☐ **Yes** ☐ **No**

**If "YES", do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you are working under these conditions?** ☐ **Yes** ☐ **No**

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**2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (such as gases, fumes, or dust) OR have you come into skin contact with hazardous chemicals?**

☐ **Yes** ☐ **No**

**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 | EXPLAIN "YES" ANSWERS: |
|---|---|---|---|
| Asbestos | ☐ | ☐ | |
| Silica (e.g., in sandblasting) | ☐ | ☐ | |
| Tungsten / cobalt (e.g., grinding or welding material) | ☐ | ☐ | |
| Beryllium | ☐ | ☐ | |
| Aluminum | ☐ | ☐ | |
| Coal (e.g, mining) | ☐ | ☐ | |
| Iron | ☐ | ☐ | |
| Tin | ☐ | ☐ | |
| Dusty environments | ☐ | ☐ | |
| Any other hazardous exposures | ☐ | ☐ | |

**If "YES", describe these exposures:** _____

_____

_____

**4. List any second jobs or side businesses you may have**: _____

_____

_____

**5. List your previous occupations:** _____

_____

_____

**6. List your current and previous hobbies:** _____

_____

_____

**7. Have you been in the military services?** ☐ Yes ☐ No

**If "YES", were you exposed to biological or chemical agents (either in training or combat?**
☐ **Yes** ☐ **No**

**8. Have you ever worked on the HAZMAT team?** ☐ Yes ☐ No

**9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizure mentioned earlier in this questionnaire, are you taking any other mediations for any reason (including over-the-counter medication)?** ☐ **Yes** ☐ **No**

**If "YES", please name them:** _____

_____

| **10. Will you be using any of the following items with your respirator?** | **YES** | **NO** | **EXPLAIN "YES" ANSWERS:** |
|---|---|---|---|
| HEPA filters | ☐ | ☐ | _____ |
| Canisters (for example, gas masks) | ☐ | ☐ | _____ |
| Cartridges | ☐ | ☐ | _____ |

| **11. How often are you expected to use the respirator?** | **YES** | **NO** | **EXPLAIN "YES" ANSWERS:** |
|---|---|---|---|
| Escape-only (no rescue) | ☐ | ☐ | _____ |
| Emergency rescue only | ☐ | ☐ | _____ |
| Less than 5 hours per week | ☐ | ☐ | _____ |
| Less than 2 hours per day | ☐ | ☐ | _____ |
| 2 to 4 hours per day | ☐ | ☐ | _____ |
| 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)?** ☐ **Yes** ☐ **No**

*Examples of "light work effort" are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3lbs.) or controlling machines.*

**If "YES", how long does this period last during the average shift?_____hours_____minutes**

**b. "moderate" (200 to 350 kcal per hour)?** ☐ **Yes** ☐ **No**

*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.*

**If "YES", how long does this period last during the average shift?_____hours_____minutes**

**C. "heavy" (about 350 kcal per hour)?** ☐ **Yes** ☐ **No**

*Examples of "heavy work load" 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 a 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.)*

**If "YES", how long does this period last during the average shift?_____hours_____minutes**

**13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you are using your respirator?** ☐ **Yes** ☐ **No**

**If "YES", please describe the protective clothing:** _____

_____

**14. Will you be working under hot conditions (temperature exceeding 77°F?** ☐ **Yes** ☐ **No**

**15. Will you working under humid conditions?** ☐ **Yes** ☐ **No**

**16. Describe the work you will be doing while using your respirator(s):** _____

_____

_____

**17. Describe any special or hazardous conditions you might encounter when you are 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 will be exposed to when you are using your respirator(s):**

**Name of 1st toxic substance:** _____

**Estimated maximum exposure level per shift:** _____

**Duration of exposure per shift:** _____

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**Name of 2nd toxic substance:** _____

**Estimated maximum exposure level per shift:** _____

**Duration of exposure per shift:** _____

**Name of 3rd toxic substance:** _____

**Estimated maximum exposure level per shift:** _____

**Duration of exposure per shift:** _____

**Please provide the name of any other toxic substances that you will exposed to while wearing your respirator(s):** _____

_____

_____

**19. Describe any special responsibilities you will have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue or security):** _____

_____

_____

**********

**I shall report to management any changes in my health condition that are related to my ability to use a respirator.**

**I understand, hereby certify that the answers to the above questions are true to the best of my knowledge.**

_____ _____ _____

**Employee Signature** **Date** **Time**

_____ _____ _____

**Occupational Health** **Reviewed Date** **Reviewed Time**

**Comments:** _____

_____ _____ _____

**Provider Signature** **Date** **Time**