**Appendix C to 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: Can you read (circle one): Yes 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 you 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. Your Age (to nearest year):
4. Sex (circle one): Male 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):

1. The best time to phone you at this number:
2. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one)

 Yes No

1. Check the type of respirator you will use (you can check more than one category):
	1. \_\_\_\_\_N, R, or P disposable respirator (filter-mask, non-cartridge type only).
	2. \_\_\_\_\_Other type (for example, half-or full-facepiece type, powered – air purifying, supplied- air, self-contained breathing apparatus).
2. 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?
	1. Seizures (fits): Yes No
	2. Diabetes (sugar disease): Yes No
	3. Allergic reactions that interfere with your breathing:

 Yes No

* 1. Claustrophobia (fear of closed-in places): Yes No
	2. Trouble smelling odors (except when you had a cold):

 Yes No

1. Have you ever had any of the following pulmonary or lung problems?
	1. Asbestosis: Yes No
	2. Asthma: Yes No
	3. Chronic bronchitis: Yes No
	4. Emphysema: Yes No
	5. Pneumonia: Yes No
	6. Tuberculosis: Yes No
	7. Silicosis: Yes No
	8. Pneumothorax: Yes No
	9. Lung Cancer: Yes No
	10. Broken ribs: Yes No
	11. Any chest injuries or surgeries: Yes No
	12. Any other lung problem that you’ve been told about: Yes No
2. Do you currently have any of the following symptoms of pulmonary or lung illness?
	1. Shortness of breath: Yes No
	2. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes No
	3. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes No
	4. Have to stop for breath when walking at your own pace on level ground: Yes No
	5. Shortness of breath when washing or dressing yourself:

 Yes No

* 1. Shortness of breath that interferes with your job: Yes No
	2. Coughing that produces phlegm (thick sputum): Yes No
	3. Coughing that wakes you early in the morning: Yes No
	4. Coughing that occurs mostly when you are lying down: Yes No
	5. Coughing up blood in the last month: Yes No
	6. Wheezing: Yes No
	7. Wheezing that interferes with your job: Yes No
	8. Chest pain when you breathe deeply: Yes No
	9. Any other symptoms that you think may be related to lung problems: Yes No
1. Have you ever had any of the following cardiovascular or heart problems?
	1. Heart attack: Yes No
	2. Stroke: Yes No
	3. Angina: Yes No
	4. Heart failure: Yes No
	5. Swelling in your legs or feet (not caused by walking): Yes No
	6. Heart arrhythmia (heart beating irregularly): Yes No
	7. High blood pressure: Yes No
	8. Any other heart problem that you’ve been told about: Yes No
2. Have you ever had any of the following cardiovascular or heart symptoms?
	1. Frequent pain or tightness in your chest: Yes No
	2. Pain or tightness in your chest during physical activity: Yes No
	3. Pain or tightness in your chest that interferes with your job:

 Yes No

* 1. In the past two years, have you noticed you heart skipping or missing a beat: Yes No
	2. Heartburn or indigestion that is not related to eating: Yes No
	3. Any other symptoms that you think may be related to heart or circulation problems: Yes No
1. Do you currently take medication for any of the following problems?
	1. Breathing or lung problems: Yes No
	2. Heart trouble: Yes No
	3. Blood pressure: Yes No
	4. Seizures (fits): Yes No
2. Has your wearing a respirator caused any of the following problems? (If you’ve never used a respirator, check the following space \_\_ and go to question9 :)
3. Would you like to talk the health care professional who will review this questionnaire about your answers to this questionnaire: Yes No
4. Have you ever worked with any of the materials, or under of the conditions, listed below:
	1. Asbestos: Yes No
	2. Silica (e.g., in sandblasting): Yes No
	3. Tungsten/cobalt (e.g., grinding of welding this material):

 Yes No

* 1. Beryllium: Yes No
	2. Aluminum: Yes No
	3. Coal: Yes No
	4. Iron: Yes No
	5. Tin: Yes No
	6. Dusty environments: Yes No
	7. Any other hazardous exposures: Yes No
1. Have you been in the military services: Yes No
2. Have you ever worked on a HAZMAT team? Yes No
3. Describe the work you’ll be doing while you’re using your respirator(s):

1. Describe any special or hazardous conditions you might encounter when you’re using your respirator(s) (for example, confined spaces, life threatening gases):

1. Provide the following information, if you know it, for each toxic substance that you’ll be exposed to when you’re using your respirator(s):
	1. Estimated maximum exposure level per shift:

* 1. Duration of exposure per shift:

* 1. Name of the second toxic substance:

* 1. Estimated maximum exposure level per shift:

* 1. Duration of exposure per shift:

* 1. Name of the third toxic substance:

* 1. Estimated maximum exposure level per shift:

* 1. Duration of exposure per shift:

1. The name of any other toxic substances that you’ll be exposed to while using your respirator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Provide information to exposure to any biological exposure you may have been exposed to when using any type of respirator (ex. TB, MRSA…): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Describe any special responsibilities you’ll have while using your respirator(s) (ex. Cleaning and maintenance): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This concludes Your Questionnaire…

Thank you and welcome to TCID