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

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 your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

This questionnaire will be reviewed by the health care professional in Employee Health Services.

Part A Section 1.  (Mandatory) The following information must be provided by every employee.  (please print).  

| Name:_____________________________________________________________ | Date: __________________________|
| Home/cell phone # _________________________ | Job Title: ____________________________ | Age: ____________________ |
| Sex | Male | Female | Height: _______ | Weight: ________ |

1. Has your employer told you how to contact the health care professional who will review this questionnaire?  (Circle one) Yes / No

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.  (please indicate “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 (fits)    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.  Asbestos       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 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 laying down  Yes  No  
   j.  Coughing up blood in the last month  Yes  No
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
o. Do you have uncontrolled thyroid problems
p. Do you have problems with temperature regulations
q. Have you ever had “heat” stroke
r. Do you have history of heat intolerance

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 symptoms that you can think may be related to lung problems

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
c. Pain or tightness in your chest during physical activity
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

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

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. Seizures (fits)

9. Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire?

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ASSESSMENT - TO BE COMPLETED BY A NURSE OR PHYSICIAN IN THE EMPLOYEE HEALTH SERVICE

_____ Employee is cleared to perform job duties with use of a respirator
_____ Employee needs an appointment with Employee Health Service for further evaluation
_____ other recommendations:

It should be noted that medical qualification for respirator use is dependent upon proper fit testing and instruction regarding use and maintenance of respiratory equipment.

_____________________________                    ______________________
Nurse or Physician signature                    Date