OSHA Respirator Medical Evaluation Questionnaire (Mandatory)
1910.134 Appendix C

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, email this questionnaire to brooke.rhinehart@hs.c.utah.edu a health care professional who will review and contact you if there are questions or additional follow-up is needed. Be sure to add PHI to the subject line in your email.

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): _______________ Date of Birth: ___________________

4. Sex (circle one): Male Female

5. Your height: _______ ft. _______ in.

6. Your weight: _______ lbs.

7. Your employer: __________________________________________________________________

Your job title: __________________________________________________________________

8. A phone number where you can be reached by the health care professional who reviews the 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):
   a. _______ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
   b. _______ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one)? Yes No 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 (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. 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 (fits): Yes  No

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 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

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

Please explain your “Yes” responses to any of the above questions. Do your “Yes” responses represent current or past concerns? How do the symptoms or medical conditions affect your daily activity? Have the symptoms or medical conditions seemed to make using a respirator more difficult in the past (if yes, please explain)?

________________________________________  ____________________________

Signature Date