

Occupational Medicine 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, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it. **Please email to: occupational.medicine@hsc.utah.edu or fax to 801-213-4600.**

Reason for using a respirator at the University of Utah (mark all that apply):

____ Work with Animals ____ Work with Pathogenic agents/recombinant virus's
____ Work with Hazardous chemicals ____ Exposed to particulates ____ other: _____

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 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. Home Address: _____
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 |

