Occupational Safety and Health Administration (OSHA)
Respirator Medical Evaluation Questionnaire
(App. C 1910.134)
Mandatory

TO THE EMPLOYER. Affirmative answers to questions in Part A Section 2, except question 9, require a medical examination.
TO THE EMPLOYEE. Can you read? [ ] Yes [ ] No Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient for 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 heath care professional that will review it.

Supplemental Information. To be provided by the employer regarding the use of respirator and the working conditions.

1. Employer Representative:____________________ Telephone:________________

2.

Respirator Type	Weight	Duration of Use	Frequency of Use

Expected physical effort:
[ ] Light Effort (Sitting/standing while writing, performing light assembly work: or controlling machines)
[ ] Moderate Effort (Sitting/standing/walking using tools, performing assembly work, lifting/pushing moderate loads)
[ ] Heavy Effort (Lifting heavy loads (>35Ibs.); shoveling; walking up an 8º grade, climbing stairs with a load)

Expected use of additional protective clothing and/or equipment while using the respirator. [ ] Yes [ ] No

If yes, describe:________________________________

Expected working conditions:
Temperature Extremes Low: ________°F High:________°F
Humidity Extremes Low:________% High:________%

Part A. Section 1. To be completed by all applicants/employees selected to use any type of respirator. Please print.

Name	Social Security #	Sex [ ] Male [ ] Female	Date

Address	City	State	Zip Code	Job Title

Telephone ( )	Best time to reach you at this number	Date of Birth	Age	Height (ft. in.)	Weight (Ibs)

1. Has your employer told you how to contact the health care Professional who will review this questionnaire? [ ] Yes [ ] No If
2. Check the type of respirator you will use. (Check all that apply)
   [ ] N, R, or P disposable respirator
   [ ] Other types (i.e. half or full-facepiece, powered-air purifying, supplied-air, self-contained breathing apparatus).
3. Have you worn a respirator? [ ] Yes [ ] No
   If Yes, list what type(s)
   ____
   ____
   ____

Part A. Section 2. To be completed by all applicants/employees 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 interfering 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. Other lung problems 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 working at your own pace on level ground: Yes No
e. Shortness of breath when washing or dressing yourself: Yes No
f. Shortness of breath interfering with your job: Yes No
g. Coughing producing phlegm (thick sputum): Yes No
h. Coughing that wakes you early in 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 irregularity): Yes No
   g. High blood pressure: Yes No
   h. Other heart problems 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. Heart burn or indigestion 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 any medication for any of the following problems?
   a. Breathing or lung problems: Yes No
   b. Heart problems: Yes No
   c. Blood pressure: Yes No
   d. Seizures (fits): Yes No

8. Have you ever used a respirator? Yes No
   If Yes, have you had any of the following problems?
   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 problems that interfere 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? Yes No

Questions 10 to 15 must be completed by all applicants/employees selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees selected to use other types of respirators, answering these questions is voluntary. Please circle **Yes or No.**

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

11. Do you currently have any of the following vision problems?
   a. Wear contact lenses: Yes No
   b. Wear glasses: Yes No
   c. Color blind: Yes No
   d. Any other eye or vision problem: Yes No

12. Have you ever injured your ears, including a broken ear drum? Yes No

13. Do you currently have any of the following hearing problems?
   a. Difficulty hearing: Yes No
   b. Wear a hearing aid: Yes No
   c. Any other hearing or ear problem: Yes No

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

15. Do you currently have any of the following musculoskeletal problems?
   a. Weakness in any of your arms, hands, legs, or feet: Yes No
   b. Back pain: Yes No
   c. Difficulty fully moving your arms and legs: Yes No
   d. Pain or stiffness when you leaning forward or backward at the waist: Yes No
   e. Difficulty fully moving your head up or down: Yes No
   f. Difficulty fully moving your head side to side: Yes No
   g. Difficulty bending at your knees: Yes No
   h. Difficulty squatting to the ground: Yes No
   i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes No
   j. Any other muscle or skeletal problem that interferes with using a respirator: Yes No

Patient Signature:________________________ Date:________________

Healthcare Professional

Name________________________

Address________________________

Signature________________________ Date ________________