OSHA Respirator Medical Evaluation Questionnaire

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.

Part A. Section I. (Mandatory)

1. Today's date:

2. Your name:

3. Your age (to nearest year):

4. Sex (circle one): Male/Female

5. Your height: ☐ ☐

6. Your weight:

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):

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-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Part A. Section II. (Mandatory)

Questions 1 through 9 **must be answered by every employee who has been selected to use any type of respirator**. (Please circle "YES" or "NO" or check the appropriate box):

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?

Condition	Had in past	Have at Present	Never had
Seizures (fits)			
Diabetes (sugar disease)			
Allergic reactions that interfere with your breathing			
Claustrophobia (fear of closed-in Places)			
Trouble smelling odors			

3. Have you *ever had* any of the following pulmonary or lung problems?

Condition	Had in past	Have at Present	Never had
Asbestosis			
Asthma			
Chronic bronchitis			
Emphysema.			
Pneumonia			
Tuberculosis			
Silicosis			
Pneumothorax (collapsed lung)			
Lung cancer			
Broken ribs			
Any chest injuries or surgeries			
Any other lung problems that you've been told about Explain:			

4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?

Condition	Yes	No
Shortness of breath		
Shortness of breath when walking fast on level ground or walking up a slight hill or incline		
Shortness of breath when walking with other people at an ordinary pace on level ground		
Have to stop for breath when walking at your own pace on level ground		
Shortness of breath when walking or dressing yourself		
Shortness of breath that interferes with your job		
Coughing that produces phlegm (thick sputum)		

Coughing that wakes you early in the morning		
Coughing that occurs mostly when you are lying down		
Coughing up blood in the last month		
Wheezing		
Wheezing that interferes with your job		
Chest pain when you breathe deeply		
Any other symptoms that you think may be related to lung problems? Explain:		

5. Have you *ever had* any of the following cardiovascular or heart problems?

Condition	Had in past	Have at Present	Never had
Heart Attack			
Stroke			
Angina			
Heart Failure			
Swelling in your legs or feet (not caused by walking)			
Heart arrhythmia (heart beating irregularly)			
High blood pressure			
Any other heart problem that you've been told about? Explain:			

6. Have you *ever had* any of the following cardiovascular symptoms?

Condition	Had in past	Have at Present	Never had
Frequent pain or tightness in your chest			
Pain or tightness in your chest during physical activity			
Pain or tightness in your chest that interferes with your job			
In the past two years, have you noticed your heart skipping or missing a beat			
Heartburn or indigestion that is not related to eating			

Any other symptoms that you think may be related to heart or circulation problems? Explain:

7. Do you *currently* take medication for any of the following problems?

Condition	Yes	No
Breathing or lung problem		
Heart trouble		
Blood pressure		
Seizures (fits)		

8. If you've used a respirator, have you *ever had* any of the following problems?
(If you've never used a respirator go to question 9):

Condition	Yes	No
Eye irritation		
Skin allergies or rashes		
Anxiety		
General weakness or fatigue		
Any other problem that interferes with your use of a respirator? Explain:		

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: **YES** ☐ **NO** ☐

10. Have you *ever lost* vision in either eye (temporarily or permanently) **YES** ☐ **NO** ☐
If yes, was vision loss permanent? **YES** ☐ **NO** ☐

11. Do you *currently* have any of the following vision problems?

Condition	Yes	No
Wear contact lenses		
Wear glasses		
Color blind		

Any other eye or vision problem Explain:

12. Have you *ever had* an injury to your ears, including a broken eardrum? **YES** ☐ **NO** ☐

13. Do you *currently* have any of the following hearing problems?

Condition	Yes	No
Difficulty Hearing		
Wear a hearing aid		
Any other hearing or ear problems? Explain:		

14. Have you *ever had* a back injury? **YES** ☐ **NO** ☐

15. Do you *currently* have any of the following musculoskeletal problems?

Condition	Yes	No
Weakness in any of your arms, hands, legs, or feet	☐	☐
Back pain	☐	☐
Difficulty fully moving your arms and legs	☐	☐
Pain or stiffness when you lean forward or backward at the waist	☐	☐
Difficulty fully moving your head up or down	☐	☐
Difficulty fully moving your head side to side	☐	☐
Difficulty bending at your knees	☐	☐
Difficulty squatting to the ground	☐	☐
Climbing a flight of stairs or a ladder carrying more than 25 lbs.	☐	☐
Any other muscle or skeletal problem that interferes with using a respirator? Explain:		

On ___/___/___ , I do hereby attest that upon reviewing medical questionnaire and based on my best
(Date)
medical judgment, _____is (initial all that apply):
(Name)

_____ Approved to wear the following respirators:

_____ Filtering Face Piece (N-95 dust mask) Escape Only Respirator

_____ Half Mask Respirator

_____ Full Mask Respirator

_____ SCBA

_____ Are approved with the following conditions _____

_____ Not approved for respirator use

_____ _____

Signature of PLHCP Representative Date

On ___/___/___, _____passed a respiratory fit test for a_____
respirator(s) and received training in compliance with OSHA standard 29 CFR 1910.134.

_____

Signature of Safety Representative