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

Part A. Section 1. (Mandatory) Every employee who has been selected to use any type of respirator (please print) must provide the following information.

Today's date: ___________________________ Date of Birth: ___________________________
Name: ___________________________________ SSN: ___________________________
Job Title: ___________________________ Sex: Male ☐ Female ☐
Home Phone: ___________________________________ Height: ___ (ft) ___ (in) Weight ___ (lbs)
Work Phone: ___________________________________

Can you read English? ___________________________ Has your employer told you how to contact the health care professional who will review this? Yes ☐ NO ☐

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 ☐
   - Powered-air purifier ☐
   - Supplied-air ☐
   - Full-facepiece type (includes gas mask) ☐

Have you worn a respirator in the past? ___________________________ Yes ☐ NO ☐
If "yes," what type(s):

Physical exertion while wearing a respirator: Mild ☐ Moderate ☐ Strenuous ☐

Maximum time you wear a respirator in a single day?: __________ hours

Do you exercise? ___________________________ Yes ☐ NO ☐
If "yes," describe how often and what exercise activities are:

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 select "yes" or "no").

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes ☐ NO ☐
   If Yes, how many packs per day? 1/2 or less ☐ 1 ☐ 2 ☐ 2 or more ☐
   How many years have you smoked? 1-9 ☐ 10-19 ☐ 20-29 ☐ 30 or more ☐

2. Have you ever had any of the following conditions?
   - Seizures (fits) Yes ☐ NO ☐
   - Diabetes (sugar disease) Yes ☐ NO ☐
   - Allergic reactions that interfere with your breathing Yes ☐ NO ☐
   - Claustrophobia (fear of closed-in places) Yes ☐ NO ☐
   - Trouble smelling odors Yes ☐ NO ☐

3. Have you ever had any of the following pulmonary or lung problems?
   - Asbestosis Yes ☐ NO ☐
   - Asthma Yes ☐ NO ☐
   - Chronic bronchitis: Yes ☐ NO ☐
   - Emphysema: Yes ☐ NO ☐
   - Pneumonia Yes ☐ NO ☐
   - Tuberculosis Yes ☐ NO ☐
   - Silicosis Yes ☐ NO ☐
   - Pneumothorax (collapsed lung) Yes ☐ NO ☐
   - Lung cancer Yes ☐ NO ☐
   - Broken ribs: Yes ☐ NO ☐
   - Any chest injuries or surgeries: Yes ☐ NO ☐
   - 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?

- Shortness of breath:
- Shortness of breath when walking fast on level ground or walking up a slight hill/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 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

Yes  NO

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

- 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:

Yes  NO

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

- 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 symptoms that is not related to eating
- 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?

- Breathing or lung problems:
- Heart trouble:
- Blood Pressure:
- 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)

- Eye irritation:
- Skin allergies or rashes:
- Anxiety:
- General weakness or fatigue:
- 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
SUPPLEMENTAL: If you are required to use a full-face piece respirator or a Self-Contained Breathing Apparatus (SCBA), complete the following: (If you do not, please sign below.)

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?
   - Wear glasses:  Yes ☐ NO ☐
   - Wear contact lenses:  Yes ☐ NO ☐
   - Color blind:  Yes ☐ NO ☐
   - Any other eye or vision problem:  Yes ☐ NO ☐

12. Have you ever had an injury to your ears, including a broken ear drum:  Yes ☐ NO ☐

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

Any additional comments you would like to make:

____________________________________________________________________________________________________________________________________________________

To the best of my knowledge, the information I have provided is true and accurate.

Employee Signature ________________________________ Date __________________

TO BE COMPLETED BY THE EXAMINER/REVIEWER:

This employee has been found to be physically able to use the following (check each [ ] that applies):
- Single use, filter mask (four attachment points)
- Half-faced cartridge-type, negative pressure
- Full-faced cartridge-type respirator, negative pressure
- Half-faced powered cartridge-type (PAPR)
- Full-faced powered cartridge-type (PAPR)
- Self-contained breathing apparatus (SCBA)
- Hood/helmet powered cartridge-type (PAPR)
- Half-faced/Full-faced/Hood/Helmet (NOT positive pressure)

Restrictions / Limitations (if any) when wearing a respirator:

☐ This employee has been found to be physically NOT able to use a respirator
☐ There is insufficient information to make a determination at this time
☐ The mandatory questionnaire has been reviewed, and the employee has been found to be physically able to use a respirator.
☐ The mandatory questionnaire has been reviewed but there is insufficient information to make a determination at this time.

This respirator clearance expires 1 ☐ 2 ☐ 3 ☐ years from the date below. (If not marked, clearance expires in 1 year)

Reviewer’s Name (Print) ________________________________ Reviewer’s Signature ___________________________ Date: ________________

OSHA Respirator Questionnaire