

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

## OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

**HEALTH CARE PROVIDER SECTION:** Appendix C to 1910.134: OSHA Respiratory Medical Evaluation Questionnaire (Revised 2021)

**PLHCP Decision:**

- Medically qualified for respirator use **without** restriction
- Medically qualified for respirator use with the following restrictions: \_\_\_\_\_
- DEFER TO DECISION** – additional information required:
  - Telephone call for clarification
  - Needs further evaluation – office visit to be scheduled
- NOT** medically qualified to use a respirator

**COMMENTS:** \_\_\_\_\_

**REVIEWED BY:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**TO THE EMPLOYER:** Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

**TO THE EMPLOYEE:** 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 1. (MANDATORY)

The following information must be provided by every employee who has been selected to use any type of respirator.

**NAME:** \_\_\_\_\_ **TODAY'S DATE:** \_\_\_\_\_

**AFFILIATION:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**HOME ADDRESS:** \_\_\_\_\_  
**STREET** **CITY** **ZIP CODE**

**PHONE NUMBER:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

A phone number where you can be reached by the health care professional who reviews this questionnaire

**THE BEST TIME TO CONTACT YOU:** \_\_\_\_\_

**SEX:**  MALE  FEMALE **YOUR HEIGHT:** \_\_\_\_\_ FT. \_\_\_\_\_ IN. **YOUR WEIGHT:** \_\_\_\_\_ LBS.

Has your employer told you how to contact the health care professional who will review this questionnaire?  YES  NO

### CHECK THE TYPE OF RESPIRATOR YOU WILL USE (YOU CAN CHECK MORE THAN ONE CATEGORY)

- Half face mask (paper filter mask, covers nose and mouth, no cartridge, i.e., N-95, particulate dust mask)
- Half face mask (covers nose and mouth, made of rubber with cartridge)
- Full face mask (covers full face, made of rubber with cartridge)
- Powered Air Purifying (hood or full-face mask with filtered air supply)
- SCBA (self-contained breathing apparatus, i.e., Scott Pack)
- Have you worn a respirator?  YES  NO
- If "YES" what type(s): \_\_\_\_\_

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## OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

**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 check "YES" or "NO").

	YES	NO
<b>1. Do you <i>currently</i> smoke tobacco, or have you smoked tobacco in the last month?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Have you <i>ever had</i> any of the following conditions?</b>	<input type="checkbox"/>	<input type="checkbox"/>
a. Seizures	<input type="checkbox"/>	<input type="checkbox"/>
b. Diabetes (sugar disease)	<input type="checkbox"/>	<input type="checkbox"/>
c. Allergic reactions that interfere with your breathing	<input type="checkbox"/>	<input type="checkbox"/>
d. Claustrophobia (fear of closed-in places)	<input type="checkbox"/>	<input type="checkbox"/>
e. Trouble smelling odors	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. Have you <i>ever had</i> any of the following pulmonary or lung problems?</b>	<input type="checkbox"/>	<input type="checkbox"/>
a. Asbestosis	<input type="checkbox"/>	<input type="checkbox"/>
b. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
c. Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
d. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
e. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
f. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
g. Silicosis	<input type="checkbox"/>	<input type="checkbox"/>
h. Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/>
i. Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>
j. Broken ribs	<input type="checkbox"/>	<input type="checkbox"/>
k. Any chest injuries or surgeries	<input type="checkbox"/>	<input type="checkbox"/>
l. Any other lung problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. Do you <i>currently</i> have any of the following symptoms of pulmonary or lung illness?</b>	<input type="checkbox"/>	<input type="checkbox"/>
a. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	<input type="checkbox"/>	<input type="checkbox"/>
c. Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
d. Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
e. Shortness of breath when washing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>
f. Shortness of breath that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
g. Coughing that produces phlegm (thick sputum)	<input type="checkbox"/>	<input type="checkbox"/>
h. Coughing that wakes you early in the morning	<input type="checkbox"/>	<input type="checkbox"/>
i. Coughing that occurs mostly when you are lying down	<input type="checkbox"/>	<input type="checkbox"/>
j. Coughing up blood in the last month	<input type="checkbox"/>	<input type="checkbox"/>
k. Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
l. Wheezing that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
m. Chest pain when you breathe deeply	<input type="checkbox"/>	<input type="checkbox"/>
n. Any other symptoms that you think may be related to lung problems	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. Have you <i>ever had</i> any of the following cardiovascular or heart problems?</b>	<input type="checkbox"/>	<input type="checkbox"/>
a. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
b. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
c. Angina	<input type="checkbox"/>	<input type="checkbox"/>
d. Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
e. Swelling in your legs or feet (not caused by walking)	<input type="checkbox"/>	<input type="checkbox"/>
f. Heart arrhythmia (heart beating irregularly)	<input type="checkbox"/>	<input type="checkbox"/>
g. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
h. Any other heart problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>

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## OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

	YES	NO
<b>6. Have you <i>ever had</i> any of the following cardiovascular or heart symptoms?</b>	<input type="checkbox"/>	<input type="checkbox"/>
a. Frequent pain or tightness in your chest	<input type="checkbox"/>	<input type="checkbox"/>
b. Pain or tightness in your chest during physical activity	<input type="checkbox"/>	<input type="checkbox"/>
c. Pain or tightness in your chest that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past two years, have you noticed your heart skipping or missing a beat	<input type="checkbox"/>	<input type="checkbox"/>
e. Heartburn or indigestion that is not related to eating	<input type="checkbox"/>	<input type="checkbox"/>
f. Any other symptoms that you think may be related to heart or circulation problems	<input type="checkbox"/>	<input type="checkbox"/>
<b>7. Do you <i>currently</i> take medication for any of the following problems?</b>	<input type="checkbox"/>	<input type="checkbox"/>
a. Breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>
b. Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
c. Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
d. Seizures	<input type="checkbox"/>	<input type="checkbox"/>
<b>8. If you've used a respirator, have you <i>ever had</i> any of the following problems? If not SKIP TO #9</b>	<input type="checkbox"/>	<input type="checkbox"/>
a. Eye irritation	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin allergies or rashes	<input type="checkbox"/>	<input type="checkbox"/>
c. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
d. General weakness or fatigue	<input type="checkbox"/>	<input type="checkbox"/>
e. Any other problem that interferes with your use of a respirator	<input type="checkbox"/>	<input type="checkbox"/>
<b>9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?</b>	<input type="checkbox"/>	<input type="checkbox"/>

**QUESTIONS 10 TO 15 BELOW MUST BE ANSWERED BY EVERY EMPLOYEE WHO HAS BEEN SELECTED TO USE EITHER A FULL-FACEPIECE RESPIRATOR OR A SELF-CONTAINED BREATHING APPARATUS (SCBA). FOR EMPLOYEES WHO HAVE BEEN SELECTED TO USE OTHER TYPES OF RESPIRATORS, ANSWERING THESE QUESTIONS IS VOLUNTARY.**

	YES	NO
<b>10. Have you <i>ever</i> lost vision in either eye (temporarily or permanently)</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>11. Do you <i>currently</i> have any of the following vision problems?</b>	<input type="checkbox"/>	<input type="checkbox"/>
a. Wear contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
b. Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>
c. Color blind	<input type="checkbox"/>	<input type="checkbox"/>
d. Any other eye or vision problem	<input type="checkbox"/>	<input type="checkbox"/>
<b>12. Have you <i>ever had</i> an injury to your ears, including a broken ear drum?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>13. Do you <i>currently</i> have any of the following hearing problems?</b>	<input type="checkbox"/>	<input type="checkbox"/>
a. Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>
b. Wear a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>
c. Any other hearing or ear problem	<input type="checkbox"/>	<input type="checkbox"/>
<b>14. Have you <i>ever had</i> a back injury?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>15. Do you <i>currently</i> have any of the following musculoskeletal problems?</b>	<input type="checkbox"/>	<input type="checkbox"/>
a. Weakness in any of your arms, hands, legs, or feet	<input type="checkbox"/>	<input type="checkbox"/>
b. Back pain	<input type="checkbox"/>	<input type="checkbox"/>
c. Difficulty fully moving your arms and legs	<input type="checkbox"/>	<input type="checkbox"/>
d. Pain or stiffness when you lean forward or backward at the waist	<input type="checkbox"/>	<input type="checkbox"/>
e. Difficulty fully moving your head up or down	<input type="checkbox"/>	<input type="checkbox"/>
f. Difficulty fully moving your head side to side	<input type="checkbox"/>	<input type="checkbox"/>
g. Difficulty bending at your knees	<input type="checkbox"/>	<input type="checkbox"/>
h. Difficulty squatting to the ground	<input type="checkbox"/>	<input type="checkbox"/>
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.	<input type="checkbox"/>	<input type="checkbox"/>
j. Any other muscle or skeletal problem that interferes with using a respirator	<input type="checkbox"/>	<input type="checkbox"/>

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PLEASE EXPLAIN ALL "YES" RESPONSES

NUMBER	EXPLANATION

I CERTIFY THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

I WILL NOTIFY MANAGEMENT OF ANY CHANGES IN MY HEALTH THAT MAY AFFECT MY ABILITY TO USE A RESPIRATOR.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_