



Health and Safety Specialists

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OSHA Respirator Medical Evaluation Questionnaire

Standard Number: 1910.134 App C
Standard Title: Respiratory Protection
Subpart Number: I

Subpart Title: Personal Protective Equipment
Produced by USDOL OSHA - OCIS

*Can you read (circle one): Yes/No

***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 age (to nearest year): _____

*4. Sex (circle one): Male/Female

*5. Your height: _____ ft. _____ in.

*6. Your weight: _____ lb.

*7. Your job title: _____

*8. A phone number where you can be reached by the physician 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-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

*12. Have you worn a respirator (circle one): Yes/No

* If "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
- *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. Heartburn or indigestion that is 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 medication for any of the following problems?
- *a. Breathing or lung problems: Yes/No
 - *b. Heart trouble: Yes/No
 - *c. Blood pressure: Yes/No
 - *d. 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):
- *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 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
- *Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained or breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.
- *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 had an injury to 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. Wearing 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 lean 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 lb.: Yes/No
- *j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

*Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

*1. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes/No

If "yes" name the chemicals if you know them: _____

*3. Have you ever worked with any of the materials, or under any of the conditions listed below:

- a. Asbestos: Yes/No
- b. Silica (e.g., in sandblasting): Yes/No
- c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/No
- d. Beryllium: Yes/No
- e. Aluminum: Yes/No
- f. Coal (for example, mining): Yes/No
- g. Iron: Yes/No
- h. Tin: Yes/No
- i. Dusty environments: Yes/No
- j. Any other hazardous exposures: Yes/No

If "yes", describe these exposures: _____

*4. Have you been in the military services? Yes/No

If "yes", were you exposed to biological or chemical agents (either in training or combat): Yes/No

*5. Have you ever worked on a HAZMAT team? Yes/No

*6. Are you taking any other medications for any reason (including over-the-counter medications): Yes/No

If "yes", name the medications if you know them: _____

*7. Have you ever received vaccination for Hepatitis B? Yes/No

If "yes", when was it last administered? _____