OSHA RESPIRATOR QUESTIONNAIRE

APPENDIX C to Section 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

Your employer must allow you to answer this questionnaire during working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must tell you how to deliver or send this questionnaire to WORKMED MIDWEST for review.

Part A. Section 1. (Mandatory) the following information must be provided by every

Today's date:

Name: _____ DOB : _____

Sex:

Your job title : _____

Phone number where you can be reached by health care professional with any questions and the best time to reach you:
Home:_____Cell:_____

Has your employer told you how to contact the healthcare who will review this questionnaire? (Circle One: Yes or No)

Check the type of respirator you will use (you can check more than one category)

_____ N, R or P disposable respirator (filter-mask, non-cartridge type only)
_____ Other type (for example, half or full face piece type, powered air purifying self-contained breathing apparatus.

Have you worn a respirator (Circle One: Yes or 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.

1. Do you currently smoke tobacco or have you smoked in the last month? YES NO

2. Have you ever had any of the following conditions?

1. Seizure? YES NO
2. Diabetes? (Sugar Disease) YES NO
3. Allergic reactions that interfere with your breathing? YES NO
4. Claustrophobia? (Fear of closed in places) YES NO

3. Have you <u>ever</u> had any of the following pulmonary or lung problems?

1. Asbestosis? YES NO
2. Asthma? YES NO
3. Chronic Bronchitis? YES NO
4. Emphysema? YES NO
5. Pneumonia? YES NO
6. Tuberculosis? YES NO
7. Silicosis? YES NO
8. Pneumothorax (collapsed lung)? YES NO
9. Lung Cancer? YES NO
10. Broken Ribs? YES NO
11. Any chest injuries or surgeries? YES NO
12. Any other lung problems you have been told about? YES NO

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

1. Shortness of breath? YES NO
2. Shortness of breath when walking fast on level ground or walking up a hill or slight incline? YES NO
3. Shortness of breath when walking with other people at an ordinary pace on level ground? YES NO
4. Have to stop for breath when walking at your own pace on level ground? YES NO
5. Shortness of breath when washing or dressing yourself? YES NO
6. Shortness of breath that interferes with your job? YES NO
7. Coughing that produces phlegm (thick sputum)? YES NO
8. Coughing that wakes you early in the morning? YES NO
9. Coughing that occurs mostly when you are lying down? YES NO
10. Coughing up blood in the last month? YES NO
11. Wheezing? YES NO
12. Wheezing that interferes with your job? YES NO
13. Chest pain when you breathe deeply? YES NO
14. Any other symptoms that you think may be related to lung problems? YES NO

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

1. Heart Attack? YES NO
2. Stroke? YES NO
3. Angina? YES NO
4. Heart Failure? YES NO
5. Swelling in your hands and feet? (not caused by walking) YES NO
6. Heart arrhythmia? (heart beating irregularly) YES NO
7. High Blood Pressure? YES NO
8. Any other heart problems you have been told about? YES NO

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

1. Frequent pain or tightness in your chest? YES NO
2. Pain or tightness in your chest during physical activity? YES NO
3. Pain or tightness in your chest that interferes with your job? YES NO
4. In the past two years have you noticed your heart skipping or missing YES NO
5. Heartburn or indigestion that is not related to eating? YES NO

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

1. Breathing or lung YES NO
2. Heart trouble? YES NO
3. Blood pressure? YES NO
4. Seizures? YES NO

8. If you have used a respirator, have you ever had any of the following problems?

(If you have never used a respirator check NO and continue to question 9.)

1. Eye irritation? YES NO
2. Skin allergies or rashes? YES NO
3. Anxiety? YES NO
4. General weakness or fatigue? YES NO
5. Any other problems that interfere with your use of the respirator? YES NO

9. Would you like to talk with the health care professional who will review this questionnaire?

YES NO