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

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:

Can you read? (check 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 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 (check one):  Male / Female
5. Your height: _______ ft. _______ in.
6. Your weight: _________ lbs.
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).
12. Have you worn a respirator (check 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 check “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. ilicosis: ........................................................................................................................ □ 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-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.

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. Wear 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 lbs: ..................☐ 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. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen:.................................☐ Yes  ☐ No
   If “yes,” do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you’re working under these conditions:...........................................................................................................☐ Yes  ☐ No

2. 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
4. List any second jobs or side businesses you have: __________________________
   ________________________________________________________________

5. List your previous occupations: ____________________________
   ________________________________________________________________

6. List your current and previous hobbies: __________________________
   ________________________________________________________________

7. 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

8. Have you ever worked on a HAZMAT team? ......................... Yes  No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, 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: __________________________

10. Will you be using any of the following items with your respirator(s)?
    a. HEPA Filters: Yes  No
    b. Canisters (for example, gas masks): Yes  No
    c. Cartridges: Yes  No

11. How often are you expected to use the respirator(s)
    (check “yes” or “no” for all answers that apply to you)?
    a. Escape only (no rescue): Yes  No
12. During the period you are using the respirator(s), is your work effort:

a. Light (less than 200 kcal per hour): ......................................................... □ Yes □ No

   If “yes,” how long does this period last during the average shift:_______
   hrs.__________ mins.

   Examples of a light work effort are sitting while writing, typing, drafting, or
   performing light assembly work; or standing while operating a drill press (1-3
   lbs.) or controlling machines.

b. Moderate (200 to 350 kcal per hour): ..................................................... □ Yes □ No

   If “yes,” how long does this period last during the average shift:_______
   hrs.__________ mins.

   Examples of moderate work effort are sitting while nailing or filing; driving
   a truck or bus in urban traffic; standing while drilling, nailing, performing
   assembly work, or transferring a moderate load (about 35 lbs.) at trunk level;
   walking on a level surface about 2 mph or down a 5-degree grade about 3
   mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level
   surface.

c. Heavy (above 350 kcal per hour): .......................................................... □ Yes □ No

   If “yes,” how long does this period last during the average shift:_______
   hrs.__________ mins.

   Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor
   to your waist or shoulder; working on a loading dock; shoveling; standing
   while bricklaying or chipping castings; walking up an 8-degree grade about 2
   mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the
    respirator) when you’re using your respirator: ...................................... □ Yes □ No

   If “yes,” describe this protective clothing and/or equipment: _______________
   _____________________________________________________________________
   _____________________________________________________________________
14. Will you be working under hot conditions (temperature exceeding 77 deg. F): ..........................................................  □ Yes  □ No

15. Will you be working under humid conditions: ..................................  □ Yes  □ No

16. Describe the work you’ll be doing while you’re using your respirator(s):
____________________________________________________________________
____________________________________________________________________

17. Describe any special or hazardous conditions you might encounter when you’re using your respirator(s) (for example, confined spaces, life-threatening gases):
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

18. Provide the following information, if you know it, for each toxic substance that you’ll be exposed to when you’re using your respirator(s):

Name of the first toxic substance: ________________________________________
Estimated maximum exposure level per shift: ______________________________
Duration of exposure per shift: ______________________________

Name of the second toxic substance: ______________________________________
Estimated maximum exposure level per shift: ______________________________
Duration of exposure per shift: ______________________________

Name of the third toxic substance: ________________________________________
Estimated maximum exposure level per shift: ______________________________
Duration of exposure per shift: ______________________________

The name of any other toxic substances that you’ll be exposed to while using your respirator: ______________________________________
____________________________________________________________________
____________________________________________________________________

19. Describe any special responsibilities you’ll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security): ______________________________________
____________________________________________________________________
____________________________________________________________________

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