CHI Health

Company Care
OCCUPATIONAL HEALTH

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (MANDATORY)

Appendix C to Sec. 1910.134

OFFICE USE ONLY

Reason ☐ N95 ☐ PAPR	Employee ID Number	Date of Birth
Company	Department	

(**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 legal name (please print): _____
   Previous Last Name: _____
3. Your age (to nearest year): _____ Date of birth: _____/_____/_____
4. Sex (check one): ☐ Male ☐ Female
5. Your height: _____ ft. _____ in.
6. Your weight: _____ lbs.
7. Your job title: _____
   Location: _____ Department: _____
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: _____ ☐ a.m. ☐ p.m.
10. Has your employer told you how to contact the health care professional who will review this questionnaire (check 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 (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
   Have you **EVER** smoked tobacco or vaped?..... ☐ Yes ☐ No
   If yes, how many packs/day or how much do you vape? _____
   If yes, how many years have you smoked or vaped? _____
   If yes, and have quit smoking/vaping, how many years ago did you quit? _____

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2. Have you **EVER HAD** any of the following conditions:
   a. Seizures (fits)? ☐ Yes ☐ No
      If yes, when was your last seizure? _____
   b. Diabetes (sugar disease)? ☐ Yes ☐ No
      If yes, do you take insulin? ☐ Yes ☐ No
      If you are diabetic, have you fainted or passed out in the last year? ☐ Yes ☐ No
   c. Allergic reactions that interfere with your breathing? ☐ Yes ☐ No
      If yes, did you go to the emergency room? ☐ Yes ☐ No
   d. Claustrophobia (fear of closed-in places)? ☐ Yes ☐ No
      If yes, does claustrophobia interfere with your job? ☐ Yes ☐ No
      If yes, how much would a respirator bother your claustrophobia?
      Check: ☐ Not at all ☐ A little bit ☐ Medium ☐ A lot ☐ Not sure
   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
      If yes, do you take medicine for asthma? ☐ Yes ☐ No
      If yes, have you ever been hospitalized for asthma? ☐ Yes ☐ No
      Have you ever gone to an emergency room for asthma? ☐ Yes ☐ No
      When was your last asthmatic episode? _____
   c. Chronic bronchitis? ☐ Yes ☐ No
   d. Emphysema? ☐ Yes ☐ No
   e. Pneumonia? ☐ Yes ☐ No
      If yes, how many times have you had pneumonia? _____
      If yes, when was the last time you had pneumonia? _____
   f. Tuberculosis? ☐ Yes ☐ No
   g. Silicosis? ☐ Yes ☐ No
   h. Pneumothorax (collapsed lung)? ☐ Yes ☐ No
      If yes, how many times? _____
      If yes, when was the last time? _____
   i. Lung cancer? ☐ Yes ☐ No
   j. Broken ribs? ☐ Yes ☐ No
      If yes, how many ribs total have ever been broken? _____
      If yes, when was the last rib broken? _____
   k. Any chest injuries or chest surgeries? ☐ Yes ☐ No
   l. COVID? ☐ Yes ☐ No
      If yes, when was the last time you had COVID? _____
   m. Any other lung problem that you have 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
      If yes, is your shortness of breath worse than others' doing the same activity? ☐ Yes ☐ No
   c. Shortness of breath when walking with other people at an ordinary pace or 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

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5. Have you **EVER HAD** any of the following cardiovascular or heart problems:
   a. Heart attack? ☐ Yes ☐ No
      If yes, how many heart attacks? _____
      If yes, when was your last heart attack? _____
   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
      If yes, when was the last time? _____
   f. Heart arrhythmia (heart beating irregularly)? ☐ Yes ☐ No
   g. High blood pressure? ☐ Yes ☐ No
      If yes, what was your last blood pressure reading within the last three months? _____
   h. Any other heart problem that you have 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?
   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 have used a respirator, have you **EVER HAD** any of the following problems:
   (If you have NEVER used a respirator, check the box 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 (chest pain, shortness of breath, weakness, dizziness, other)? ☐ 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

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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 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 problems 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 are 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: _____

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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. 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
    b. Emergency rescue only? ☐ Yes ☐ No
    c. Less than five hours **per week**? ☐ Yes ☐ No
    d. Less than two hours **per day**? ☐ Yes ☐ No
    e. Two to four hours **per day**? ☐ Yes ☐ No
    f. Over four hours **per day**? ☐ Yes ☐ No

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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? _____ hours _____ minutes.
    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 to 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? _____ hours _____ minutes.
    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? _____ hours _____ minutes.
    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 are 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°F)? ☐ Yes ☐ No

15. Will you be working under humid conditions? ☐ Yes ☐ No

16. Describe the work you will be doing while you are 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 will be exposed to when you are 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 will be exposed to while using your respirator: _____

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

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