NOAA
OSHA Respirator Medical Evaluation Questionnaire (Mandatory)
Appendix C to Sec. 1910.134: Parts A&B

Part A. Section 1. (Mandatory) Every employee who has been selected to use any type of respirator (please print) must provide the following information.

Today's date ____________

Name ______________________________ Job Title ______________________________

Age ________ Male ◯ Female ◯ Height ____ (ft) __ __ (in) Weight ____ (lbs)

Phone Number: Home: ____________ Work: ____________

Have your employer told you how to contact the health care professional who will review this questionnaire (Select one): **Yes** ◯ **NO** ◯

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

☐ Half-face

☐ Full-facepiece type,

☐ Powered-air purifier

☐ Supplied-air

☐ Self-contained breathing apparatus

Have you worn a respirator(Select One): **Yes** ◯ **NO** ◯

NameIf ``yes,'' what type(s): ______________________________

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who hasbeenselected to use any type of respirator (please select ``yes'' or ``no'').

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month

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

Seizures (fits)	**Yes** ◯	**NO** ◯
Diabetes (sugar disease)	**Yes** ◯	**NO** ◯
Allergic reactions that interfere with your breathing	**Yes** ◯	**NO** ◯
Claustrophobia (fear of closed-in places)	**Yes** ◯	**NO** ◯
Trouble smelling odors	**Yes** ◯	**NO** ◯

3. Have you ever had any of the following pulmonary or lung problems?

Asbestosis	**Yes** ◯	**NO** ◯
Asthma	**Yes** ◯	**NO** ◯
Chronic bronchitis:	**Yes** ◯	**NO** ◯
Emphysema:	**Yes** ◯	**NO** ◯
Pneumonia	**Yes** ◯	**NO** ◯
Tuberculosis	**Yes** ◯	**NO** ◯
Silicosis	**Yes** ◯	**NO** ◯
Pneumothorax (collapsed lung)	**Yes** ◯	**NO** ◯
Lung cancer	**Yes** ◯	**NO** ◯
Broken ribs:	**Yes** ◯	**NO** ◯
Any chest injuries or surgeries:	**Yes** ◯	**NO** ◯
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?

Shortness of breath:	Yes ◯ NO ◯
Shortness of breath when walking fast on level ground or walking up a slight hill/incline	Yes ◯ NO ◯
Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes ◯ NO ◯
Have to stop for breath when walking at your own pace on level ground:	Yes ◯ NO ◯
Shortness of breath when washing or dressing yourself:	Yes ◯ NO ◯
Shortness of breath that interferes with your job:	Yes ◯ NO ◯
Coughing that produces phlegm (thick sputum):	Yes ◯ NO ◯
Coughing that wakes you early in the morning:	Yes ◯ NO ◯
Coughing that occurs mostly when you are lying down:	Yes ◯ NO ◯
Coughing up blood in the last month:	Yes ◯ NO ◯
Wheezing:	Yes ◯ NO ◯
Wheezing that interferes with your job:	Yes ◯ NO ◯
Chest pain when you breathe deeply:	Yes ◯ NO ◯
Any other symptoms that you think may be related to lung	Yes ◯ NO ◯

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

Heart attack	Yes ◯ NO ◯
Stroke:	Yes ◯ NO ◯
Angina:	Yes ◯ NO ◯
Heart Failure:	Yes ◯ NO ◯
Swelling in your legs or feet (not caused by walking):	Yes ◯ NO ◯
Heart arrhythmia (heart beating irregularly):	Yes ◯ NO ◯
High blood pressure:	Yes ◯ NO ◯
Any other heart problem that you've been told about:	Yes ◯ NO ◯

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

Frequent pain or tightness in your chest :	Yes ◯ NO ◯
Pain or tightness in your chest during physical activity	Yes ◯ NO ◯
Pain or tightness in your chest that interferes with your job	Yes ◯ NO ◯
In the past two years, have you noticed your heart skipping or missing a beat :	Yes ◯ NO ◯
Heartburn or symptoms that is not related to eating	Yes ◯ NO ◯
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?

Breathing or lung problems:	Yes ◯ NO ◯
Heart trouble:	Yes ◯ NO ◯
Blood Pressure:	Yes ◯ NO ◯
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 arespirator, check the following space and go to question 9)

Yes ◯ NO ◯

Eye irritation:	Yes ◯ NO ◯
Skin allergies or rashes:	Yes ◯ NO ◯
Anxiety:	Yes ◯ NO ◯
General weakness or fatigue:	Yes ◯ NO ◯
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 aboutyouranswers to this questionnaire:

Yes ◯ NO ◯

Questions 10-15 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 othertypes 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 visionproblems?

- Wear glasses: **Yes** ◯ **NO** ◯
- Wear contact lenses: **Yes** ◯ **NO** ◯
- Color blind: **Yes** ◯ **NO** ◯
- 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?

- Difficulty hearing: **Yes** ◯ **NO** ◯
- Wear a hearing aid: **Yes** ◯ **NO** ◯
- 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?

- Weakness in any of your arms, hands, legs, or feet: **Yes** ◯ **NO** ◯
- Back pain: **Yes** ◯ **NO** ◯
- Difficulty fully moving your arms and legs: **Yes** ◯ **NO** ◯
- Pain or stiffness when you lean forward or backward at the waist: **Yes** ◯ **NO** ◯
- Difficulty fully moving your head up or down: **Yes** ◯ **NO** ◯
- Difficulty fully moving your head side to side: **Yes** ◯ **NO** ◯
- Difficulty bending at your knees: **Yes** ◯ **NO** ◯
- Difficulty squatting to the ground: **Yes** ◯ **NO** ◯
- Climbing a flight of stairs or a ladder carrying more than 25 lbs: **Yes** ◯ **NO** ◯
- 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: ______________________________

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

Substance/Conditions Description of exposure (only if answer is yes) ______________________

- Asbestos **Yes** ◯ **NO** ◯
- Silica (e.g., in sandblasting) **Yes** ◯ **NO** ◯
- Tungsten/cobalt (e.g., grinding or welding this material) **Yes** ◯ **NO** ◯
- Beryllium: **Yes** ◯ **NO** ◯
- Aluminum **Yes** ◯ **NO** ◯

Coal (for example, mining) Yes ◯ NO ◯

Iron: Yes ◯ NO ◯

Tin: Yes ◯ NO ◯

Dusty environments: Yes ◯ NO ◯

Any other hazardous exposures: 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 t he 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) (select ``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 5 hours per week: Yes ◯ NO ◯

D) Less than 2 hours per day: Yes ◯ NO ◯

E) 2 to 4 hours per day: Yes ◯ NO ◯

F)Over 4 hours per day:: Yes ◯ NO ◯

12. During the period you are using the respirator(s), is your work effort:

Light (less than 200 kcal per hour):	Yes ◯ NO ◯	If ``yes,'' average time/shift:	______ Hours ______ 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			
Moderate (200 to 350 kcal per hour):	Yes ◯ NO ◯	If ``yes,'' average time/shift:	______ Hours ______ 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.			
Heavy (above 350 kcal per hour):	Yes ◯ NO ◯	If ``yes,'' average time/shift:	______ Hours ______ 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 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):

To the best of my knowledge, the information I have provided is true and accurate.

Employee Name **Date**

Employee Signature

TO BE COMPLETED BY THE EXAMINER/REVIEWER:

Respirator Clearance

(select one box , and provide comments as appropriate)

This employee has been found to be physically able to use the following (check each [ ] that applies):

- ☐ Single use, filter mask (four attachment points)
- ☐ Half-faced cartridge-type, negative pressure
- ☐ Full-faced cartridge-type respirator, negative pressure
- ☐ Half-faced powered cartridge-type (PAPR)
- ☐ Full-faced powered cartridge-type (PAPR)
- ☐ Self-contained breathing apparatus (SCBA)
- ☐ Hood/helmet powered cartridge-type (PAPR)
- ☐ Half-faced/Full-faced/Hood/Helmet (NOT positive pressure)

When wearing a respirator, the employee has been informed to limit activity level1 to the following (check one [ ]):

- ☐ Mild Exertion
- ☐ Moderate Exertion
- ☐ Heavy Exertion (No specified limitations)

Other limitations needed (if any) when wearing a respirator:

Circle one:

This respirator clearance expires

This respirator clearance expires 1 ◯ 2 ◯ 3 ◯ years from the date below. (*If not marked, clearance expires in 1 year*)

☐ ***This employee has been found to be physically NOT able to use a respirator***

☐ ***There is insufficient information to make a determination at this time***

The following additional tests, or medical information, will be required in order to make a determination regarding the safe use of a respirator by this employee (*If a physical examination is required to make a determination, please use the MSP form*)

☐ ***The mandatory questionnaire has been reviewed, and the employee has been found to be physically able to use a respirator.***

☐ ***The mandatory questionnaire has been reviewed but there is insufficient information to make a determination at this time.***

The following additional tests, or medical information, will be required in order to make a determination regarding the safe use of a respirator by this employee (*If a physical examination is required to make a determination, please use the MSP form*)

Reviewer's Name (Print)	**Reviewer's Signature**	**Date:**

1 Light/Mild exertion (2-3 METS)= negligible lifting, extended walking (flat surface), extended standing, writing
Moderate exertion (4-5 METS) = lifting 10lbs (5 or more lifts/min), fast walking (4mph), gardening/digging, pushing, pulling
Heavy exertion (5-10 METS) = jogging (10 minute mile), chopping wood, climbing hills, life-saving activities, firefighting,