OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (29 CFR 1910.134 APP. C)

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). Please answer all of the questions as completely and carefully as you can. If you do not understand any of the questions, please ask for assistance.

1. Today's date:____
2. Your name:____
3. Your age (to nearest year):_________ Employee ID# ________________________
4. Sex (circle one): Male / Female
5. Your height: _________________________ft. _____________________________in.
6. Your weight:____lbs.
7. Your job title:____
8. Your department:____
9. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the area code): _____________________________
10. The best time to phone you at this number:___________________________________
11. Has you employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes / No
12. Check the type of respirator you will use (you can check more than one category):

    a. ____ Disposable respirator (N, R, or P 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).
13. Have you worn a respirator before (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 problems 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 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. Hearth trouble: Yes / No
    c. Blood pressure: Yes / No
    d. Seizures: 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

Part B.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in place that has lower than normal amounts of oxygen: 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

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: ____

    ____

    ____

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4. List any second job or side business you have: ___________________________________

   ____

5. List any previous occupations: ____

   ____

6. List your current and previous hobbies: ____

   ____

7. Have you been in the military services? Yes / No
   a. 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
   a. 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: No
    b. Canisters (for example, gas masks): No
    c. Cartridges: No

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you) ?
    a. Escape only (no rescue): No
    b. Emergency rescue only: No
    c. Less than 5 hours per week: No
    d. Less than 2 hours per day: Yes
    e. 2 to 4 hours per day: No
    f. Over 4 hours per day: 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 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

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

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

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'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: ____

19. The name of any other toxic substances that you'll be exposed to while using your respirator:
    ____

20. 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):

    ____

____
Employee Signature Date

____
Print Name

PLHCP's Evaluation

The employee above may wear the above noted respirator: Yes / No
The employee above is to be referred to follow-up Physician's Evaluation: Yes / No

____
Reviewer Signature Date

____
Print Name

Physician's Evaluation *(if required)*

The employee above May: ____________ May not: ____________wear the above noted respirator.

The restrictions for respirator use by this employee are: _____________________________

____

____

____

____
Examining Physician's Signature Date

____
Print Name

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PLHCP's notes: The employee may wear the noted respirator: Yes / No

OSHA RESPIRATOR FIT TEST RECORD

This section to be filled out by employee:

Employee Name: ______________________________ Employee ID# or last four digits of SS#: __________

Employee Department: ______________________________ Date: ______________________________

Does the subject have a saccharine allergy? ❑ Yes ❑ No

Does the subject wear prescription glasses? ❑ Yes ❑ No

Acknowledgement of Understanding of User Instructions and Limitations

I understand the User Instructions for the type of respirator model used during the test procedure and the limitations of the respirator. I will follow these instructions every time I use the respirator.

Signature of fit test subject: ______________________________

This section to be filled out by person conducting fit test:
FIT TEST CONDUCTED BY / DEPARTMENT:____________________

Respirator type, model and brand
Type: **N95 Filtering Face piece** Model: **8511** Brand: **3M**

NIOSH approval number: 84A-1299

❑ Small ❑ Regular ❑ Universal

HAS A WAY FOR THE SUBJECT TO WEAR PRESCRIPTION GLASSES WHILE WEARING THE RESPIRATOR BEEN ARRANGED? ❑ YES ❑ NO

Fit Checks
❑ Satisfactory Positive Pressure Fit Check ❑ Satisfactory Negative Pressure Fit Check

Fit Test
Qualitative Fit Test Equipment: __ 3M FT-30 Kit __ Other:

Test agent used: __ Saccharin _Other:

Sensitivity
❑ 10 squeezes or less ❑ 20 squeezes ❑ 30 squeezes ❑ Test subject not sensitive

Is the test subject approved or disapproved for the use of the selected respirator?
❑ Approved ❑ Disapproved

If disapproved indicate the reason for the disapproval:
❑ Presence of facial hair in the sealing area
❑ Was not sensitive to test agent
❑ None of the masks tested created a seal
❑ Presence of scars or other interference with the sealing surface
❑ Displayed symptoms of panic while wearing a respirator
❑ The subject refused to take the fit test

Other reason(s): ______________________________

SIGNATURE OF PERSON CONDUCTING FIT-TEST: ____________________