OSHA Respirator Medical Evaluation Questionnaire (Mandatory)
(Appendix C to Section 1910.134)
Modified Form for Use with N95 Respirator ONLY

(Note 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 (circle 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: Male Female
5. Your height: _____ ft. ____ in. 6. Your weight: _____ lbs.
7. Your job title:_____ Service/Mail Code: _____
8. A phone number where you can be reached by the healthcare professional who reviews this questionnaire (include the area code): _____.
9. The best time to phone you at this number: _____AM PM
10. Has your employer told you how to contact the healthcare professional who will review this questionnaire? (circle one): **[The healthcare professional who will review this questionnaire is the occupational health care provider in the Ambulatory Care Service Occupational Health Unit (OHU), at 71977. For questions regarding fit-testing, training or the respirator, contact Safety Service Industrial Hygienist at 72080.] Yes, See above.** No
11. Check the type of respirator you will use: **N disposable respirator (filter-mask, non-cartridge type only).**

    b. **N/A** 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? (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.

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 No3.

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 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/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 symptom 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 here _____ and go on 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 healthcare professional who will review this questionnaire about your answers to this questionnaire **(If yes, call Occupational Health Unit at 71977.)** Yes No

10. If you have questions about the respirator use, workplace hazards or fit-testing, contact Safety Service Industrial Hygienist at 7-2080.

Employee Printed Name _____ Signature _____

Date _____

FOR OCCUPATIONAL HEALTH PROVIDER USE ONLY

1. Medically cleared to use the N95 respirator (filter mask).

2. Medically cleared with restrictions as shown: _____

_____

3. Further evaluation needed.

4. Medically not cleared.

_____

(Printed Name/Signature) Date
Occupational Health Provide