

**OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE**  
**1910.134 Appendix D (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?       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)**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employee Number: \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Job Title: \_\_\_\_\_

Height: \_\_\_\_\_ ft. \_\_\_\_ in.

Weight: \_\_\_\_\_ lbs.

Phone number where you can be reached by the Health Care Professional who reviews this questionnaire (including Area Code): \_\_\_\_\_ Best time to reach you at this number: \_\_\_\_\_ days

Has your employer told you how to contact the health care professional who will review this questionnaire?

Yes  No

Check the type of respirator you will use (you can check more than one category):

N, R, or P disposable respirator (filter-mask, non-cartridge type only) **N95**

Other type (for example, half – or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

Have you ever worn a respirator?     Yes  No If yes, what type(s): \_\_\_\_\_

**Part A. Section 2. (Mandatory)**

**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  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Diabetes (sugar disease)                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Allergic reactions that interfere with your breathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Claustrophobia (fear of closed-in places)             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Trouble smelling odors                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. Asbestosis  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Asthma  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Chronic Bronchitis                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Emphysema   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Pneumonia   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Tuberculosis  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Silicosis   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Pneumothorax / Collapsed lung                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Lung cancer   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Broken ribs   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k. Any chest injuries or surgeries                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| l. Any other lung problems that you've been told about | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**4. Do you currently have any of the following symptoms of pulmonary or lung illness?**

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- 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 in an ordinary place  Yes  No
- d. Have to stop for breath when walking at your own pace on ground level  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 up 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 problem?**

- 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 problems 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 had used a respirator, check the following 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 problems 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