XXX Medical Center

OSHA RESPIRATOR USE MEDICAL QUESTIONNAIRE (MANDATORY) – 1910.134AppC
N95, PAPR, Half-Mask or Supplied Air

TO THE EMPLOYEE: 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. If you have any questions regarding this questionnaire or the reviewal process, please contact ABC Company at 111-111-1111 to speak to the designated personnel who oversees the respirator medical evaluations, in the Occupational Medicine Department.

PART A. SECTION 1. Every employee who has been selected to use any type of respirator must provide the following information. **All questions are mandatory.** (please print)

CAN YOU READ? YES OR NO (Please circle one)

Date:______________________ Job Title:____

Name:____

Age:____________ Date of Birth:_____________________ Sex: Male or Female (Circle One)

Height: _______feet _____inches Weight: ___________ pounds

A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): ___________________________________

The best time to phone you at this number: ________________________________

Home Address:____________________________ City ________________ State____ Zip ____________

Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes No (XXXMedical Center – Occupational Medicine)

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

_____ N, R, or P disposable respirator (Filter-mask, non cartridge type only)
_____ Other type (for example, half or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

Have you worn a respirator? Yes or No (circle one)
If yes, What type(s)?____
____

PART A. SECTION 2. **MANDATORY.** Every employee who has been selected to use any type of respirator must answer questions 1 through 9 below.

If "YES" answer to any of the following question, an explanation is required on page 3.

	YES	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?		
a. Seizures (fits)?		
b. Diabetes (sugar disease)?		
c. Allergic reactions that interfere with your breathing?		
d. Claustrophobia (fear of closed-in places)?		
e. Trouble smelling odors?		
3. Have you ***ever had*** any of the following pulmonary or lung problems?		
a. Asbestosis?		
b. Asthma?		
c. Chronic Bronchitis?		
d. Emphysema?		
e. Pneumonia?		
f. Tuberculosis?		
g. Silicosis?		
h. Pnuemothorax (collapsed lung)?		
i. Lung Cancer?		
j. Broken Ribs?		
k. Any chest injuries or surgeries?		
l. Any other lung problems that you've been told about?		
4. Do you ***currently*** have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath?		
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline?		
c. Shortness of breath when walking with other people at an ordinary pace on level ground?		
d. Have to stop for breath when walking at your own pace on level ground?		
e. Shortness of breath when washing or dressing yourself?		
f. Shortness of breath interferes with your job?		
g. Coughing that produces phlegm (thick sputum)?		
h. Coughing that wakes you early in the morning?		
i. Coughing that occurs mostly when you are lying down?		
j. Coughing up blood in the last month?		
k. Wheezing?		
l. Wheezing that interferes with your job?		
m. Chest pain when you breathe deeply?		
n. Any other symptoms that you think may be related to lung problems?		
5. Have you ***ever had*** any of the following cardiovascular or heart problems?		
a. Heart attack?		
b. Stroke?		
c. Angina?		
d. Heart failure?		
e. Swelling in your legs or feet (not caused by walking)?		
f. Hearth arrhythmia (heart beating irregularly)?		

	YES	NO
g. High blood pressure?		
h. Any other heart problem that you've been told about?		
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?		
c. Pain or tightness in your chest that interferes with your job?		
d. In the past two years, have you noticed your heart skipping or missing a beat?		
e. Heartburn or indigestion that is not related to eating?		
f. Any other symptoms that you think may be related to heart or circulation problems?		
7. Do you ***currently*** take medication for any of the following problems?		
a. Breathing or lung problems?		
b. Heart trouble?		
c. Blood Pressure?		
d. Seizures (fits)?		
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?		
b. Skin allergies or rashes?		
c. Anxiety?		
d. General weakness or fatique?		
e. Any other problems that interferes with your use of a respirator?		
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?		

Please comment below if "YES" was answered to any questions.

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____

The information provided in this questionnaire is true and correct to the best of my knowledge.

Employee Signature: ____ Date:__________________

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DO NOT WRITE BELOW THIS LINE

____ Date: ___________________

Signature of Licensed Health Care Professional reviewed by

Comments: