Occupational Safety and Health Administration (OSHA)

Respirator Medical Evaluation Questionnaire.

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (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:

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**.

PLEASE EMAIL ALL COMPLETED FORMS TO:

TYLER.BAX@HEALTH.MO.GOV & UMHSOCCMEDJC@HEALTH.MISSOURI.EDU

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. Date of Birth: _____
4. Sex (check one): _____
5. Your height: _____Ft._____in.
6. Your weight: _____lbs.
7. Your job title: _____
8. A phone number where you can be reached by the healthcare professional who reviews this questionnaire: ..……..... _____
9. The best time to phone you at this number: ……..... _____
10. Has your employer told you how to contact the healthcare professional who will review this questionnaire (check one): .....…… ☐ Yes ☐ No
11. What type of respirator you will use (you can list more than one): N, R, or P disposable respirator (filter-mask, non-cartridge type only)…… _____

    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 (check 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 check "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 ……..... ☐ 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 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 ☐ 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 *<u>ever</u> 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): …….

g. High blood pressure: …… ☐ Yes ☐ No

h. Any other heart problem that you've been told about: ……. ☐ Yes ☐ No

6. Have you *<u>ever</u> 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

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: …… ☐ 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 healthcare professional who will review this questionnaire about your answers to this questionnaire?** : …… ☐ Yes ☐ No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA).

10. **Have you ***ever lost*** vision in either eye (temporarily or permanently)?** : …… ☐ Yes ☐ No
11. **Do you ***currently*** have any of the following vision problems?**
    a. Wear contact lenses: ……... ☐ Yes ☐ No
    b. Wear glasses: ……... ☐ Yes ☐ No
    c. Color blind: …… ☐ Yes ☐ No
    d. Any other eye or vision problem: ……... ☐ Yes ☐ No
11. **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?

a. Difficulty hearing: ……. ☐ Yes ☐ No
b. Wear a hearing aid: ……. ☐ Yes ☐ No
c. 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?

a. Weakness in any of your arms, hands, legs, or feet: ……. ☐ Yes ☐ No
b. Back pain: ……. ☐ Yes ☐ No
c. Difficulty fully moving your arms and legs: …….. ☐ Yes ☐ No
d. Pain or stiffness when you lean forward or backward at the waist: …….. ☐ Yes ☐ No
e. Difficulty fully moving your head up or down: …….. ☐ Yes ☐ No
f. Difficulty fully moving your head side to side: ……. ☐ Yes ☐ No
g. Difficulty bending at your knees: …… ☐ Yes ☐ No
h. Difficulty squatting to the ground: ……..... ☐ Yes ☐ No
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.: ☐ Yes ☐ No
j. 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 healthcare 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:

   _____

   _____

   _____

   _____

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:

   _____

   _____

   _____

   _____

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? :

   _____

   _____

   _____

   _____

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
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) (check "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), what is your work effort?:

a. *Light* (less than 200 kcal per hour): …….. ☐

Examples: *sitting* while writing, typing, drafting, or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines.

If "yes," how long does this period last during the average shift: ….

b. *Moderate* (200 to 350 kcal per hour): …….. ☐

Examples: *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.

If "yes," how long does this period last during the average shift: ……

c. *Heavy* (above 350 kcal per hour): …… ☐

Examples: *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.).

If "yes," how long does this period last during the average shift: ……

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 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:

_____

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, and security):

_____

_____

_____

_____

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998; 76 FR 33607, June 8, 2011; 77 FR 46949, Aug. 7, 2012]

(OPTIONAL)

Physician reviewing this questionnaire:

MU Healthcare – Occupational Medicine Clinic

Greggory Kuhlman, DO

573-896-1197

umhsoccmedjc@health.missouri.edu

Must submit additional Authorization for Examination or Treatment on next page

CLEAR FORM

PRINT

(OPTIONAL) EMAIL COMPLETED FORM TO CRMC-OCC Med

MU Health Care

Occupational Medicine
Greggory Kuhlmann, DO
Eddie W. Runde MD, MPH
Ashley Hardesty, FNP

Phone: (573) 86-1197
Fax: (573) 634-0028
915 Eastland Drive
Suite A
Jefferson City, MO 65101

Authorization for Examination or Treatment

(Patient Must Present Photo ID at Time of Service)
Authorization can be faxed to 573-817-3103 or emailed to
occupationalmedicine@health.missouri.edu (Columbia, MO)
umhsoccmedjc@health.missouri.edu (Jefferson City, MO)

Patient Name: _____ Date of Service: _____

Employer:_____Phone Number:_____

Physical Examination

□ Preplacement □ Baseline □Annual □ Exit Circle one: DOT or Non DOT

Drug Screen:

□ Instant
- □ 4-Panel
- □ 5-panel
- □10-Panel
- □12-panel

□ Send out with chain of custody
Circle one: DOT or Non DOT

□ Hair Test Collection
Circle one: DOT or Non-DOT

□ BAT
Circle one: DOT or Non-DOT

Lab Draw:

□ Measles Titer
□ Mumps Titer
□ Rubella Titer
□ Varicella Titer
□ QFT
□ CMP
□ CBC w/ Diff
□ Hep B Titer
□ Other: _____

Additional Testing

□ Audiogram
□ Otoscopic exam
□ Ishihara
□ Hazmat PE
□ EKG with interpretation
□ Chest X-Ray (circle one): 1-view 2-view
□ Urinalysis
□ PPD/TB Test (circle one): 1 Step 2 Step

Respiratory

□ Spirometry (PFT)
□ N-95 Fit Test
□ Full respirator mask fit
□ 1/2 respirator mask fit
□ Resp. Clearance Certificate
□ OSHA Paperwork

Special instructions/comments: _____
_____

Send results to:
Fax#: _____ Email: _____

Authorized by: _____ Title: _____
Please print

Phone: (_____) _____ _____
Date

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
REQUEST FOR MEDICAL CLEARANCE

I request that the employee named below have a medical clearance performed in accordance with the OSHA Respiratory Protection Standard, 29 CFR 1910.134(e). **I understand that this individual may not wear any type of respirator until the medical clearance is received, they have submitted proof of training, and a passed a fit test in the make, model, style, and size of respirator they will be wearing.**

_____ _____

Supervisor's Signature Printed Name Date

_____ _____

Regional Manager's Signature Printed Name Date

Employee's Name: _____ DOB: _____

Region (SCLR): _____ Start Date:_____ Date OSHA-C emailed: _____

Supervisor's Email Address:_____

Employee's Email Address:_____

**********RESPIRATORY PROTECTION PROGRAM ADMINISTRATOR USE **********

_____ _____

_____ _____

_____

_____ _____

_____

_____ _____

Date Clearance Received: _____ Date Supervisor Contacted: _____

MEDICAL DETERMINATION:

☐ CLEARED TO WEAR N95 ONLY. NO RESTRICTIONS UNLESS BOX BELOW IS CHECKED. MAY PROCEED WITH FIT TESTING.
☐ Restrictions, if any _____

☐ CLEARED TO WEAR ANY TYPE OF RESPIRATOR EXCEPT SCBA. NO RESTRICTIONS UNLESS BOX BELOW IS CHECKED. MAY PROCEED WITH FIT TESTING.
☐ Restrictions, if any _____

☐ CANNOT WEAR ANY NEGATIVE PRESSURE RESPIRATOR (N95 OR ELASTOMERIC) BUT MAY WEAR A PAPR WITH A LOOSE-FITTING HOOD.
☐ Restrictions, if any _____

☐ **NOT MEDICALLY CLEARED**. **MAY NOT CONDUCT FIT TESTING. INDIVIDUAL MAY NOT WEAR ANY TYPE OF RESPIRATOR.** MUST BE ASSIGNED ALTERNATE DUTIES THAT DO NOT REQUIRE USE OF A RESPIRATOR, OR MAY WEAR A PROCEDURE MASK AND IF NEEDED, A FACE SHIELD.

_____ _____

Respiratory Protection Program Administrator's Signature Date