OSHA Respirator Medical Evaluation Questionnaire
Section 1910.134, Appendix C (Mandatory)

Today's date:________________ Name:_____________________________ Job title:______________________________

Height: ____ft. ____in. Weight:____lbs. Birth date:_____________ Employee ID:_______ Age (to nearest year):____ Sex (circle one): Male / Female

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

The best time to phone you at this number:_________________

Has your employer told you how to contact the health care professional who will review this questionnaire? (circle one): Yes / No

Have you worn a respirator? (circle one): Yes / No If "yes," what type(s):_________________

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. Pneumothorax (collapsed lung)
   i. Lung cancer
   j. Broken ribs
   k. Any chest injuries or surgeries
   l. Any other lung problem 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 that 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

Yes / No

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. Heart arrhythmia (heart beating irregularly)
   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. 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. 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 fatigue
   e. Any other problem 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?

By answering “Yes” to any questions, I am to contact Employee Health Services (792-2991) and schedule an evaluation.

I certify the above information is correct.

Signature:_________________________________________ Date:________________

TO BE COMPLETED BY EMPLOYEE HEALTH SERVICES ONLY

Mask Fit Test
☐ Approved ☐ Denied for: N, R, or P disposable respirator (filter-mask, non-cartridge type only).
☐ Approved ☐ Denied ☐ N/A for: Other type (i.e. half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Provider Signature:______________________________ Date:_______________ ☐ Copy given, date:________________