SARATOGA HOSPITAL
MEDICAL GROUP
OCCUPATIONAL MEDICINE
2388 ROUTE 9 • MECHANICVILLE • NY • 12118
TEL: (518) 886-5412 • FAX: (518) 899-8069

DOB: Age: Sex:
ADM/SVC Date: Arrival Time:
Loc:

MR#:

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: Can you read? *Check appropriate answer.* 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 (check appropriate answer): Male ☐ Female ☐
5. Your height: _____ ft. _____ in.
6. Your weight: _____ lbs.
7. Your job title: _____
8. A phone number where you can be reached by the health care professional who review this questionnaire (include the area code). _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire (check appropriate box) Yes ☐ No ☐
11. 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). ☐
    - Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus). ☐
12. Have you worn a respirator? (check one) Yes ☐ No ☐
    If yes, what types? _____

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 past month? Yes ☐ No ☐	
2. Have you ever had any of the following conditions?	
Yes ☐ No ☐	Seizures (fits)
Yes ☐ No ☐	Diabetes (sugar disease
Yes ☐ No ☐	Allergic reactions that interfere with your breathing

SARATOGA HOSPITAL
MEDICAL GROUP
OCCUPATIONAL MEDICINE
2388 ROUTE 9 • MECHANICVILLE • NY • 12118
TEL: (518) 886-5412 • FAX: (518) 899-8069

DOB: Age: Sex:
ADM/SVC Date: Arrival Time:
Loc:

MR#:

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

(2. Continued) Have you ever had any of the following conditions?	
Yes ☐ No ☐	Claustrophobia (fear of closed-in places)
Yes ☐ No ☐	Trouble smelling odors
3. Have you ever had any of the following pulmonary or lung problems:	
Yes ☐ No ☐	Asbestos
Yes ☐ No ☐	Asthma
Yes ☐ No ☐	Chronic bronchitis
Yes ☐ No ☐	Emphysema
Yes ☐ No ☐	Pneumonia
Yes ☐ No ☐	Tuberculosis
Yes ☐ No ☐	Silicosis
Yes ☐ No ☐	Pneumothorax (collapsed lung)
Yes ☐ No ☐	Lung Cancer
Yes ☐ No ☐	Broken ribs
Yes ☐ No ☐	Any chest injuries or surgeries. If yes, list:
Yes ☐ No ☐	Any other lung problem that you've been told about
	If yes, list:
4. Do you currently have any of the following symptoms of pulmonary or lung illness?	
Yes ☐ No ☐	Shortness of breath
Yes ☐ No ☐	Shortness of breath when walking fast on level ground or walking up a slight hill or incline
Yes ☐ No ☐	Shortness of breath when walking with other people at an ordinary pace on level ground
Yes ☐ No ☐	Have to stop for breath when walking at your own pace on level ground
Yes ☐ No ☐	Shortness of breath when washing or dressing yourself
Yes ☐ No ☐	Shortness of breath that interferes with your job
Yes ☐ No ☐	Coughing that produces phlegm (thick sputum)
Yes ☐ No ☐	Coughing that wakes you early in the morning
Yes ☐ No ☐	Coughing that occurs mostly when you are lying down
Yes ☐ No ☐	Coughing up blood in the past month
Yes ☐ No ☐	Wheezing
Yes ☐ No ☐	Wheezing that interferes with your job
Yes ☐ No ☐	Chest pain when you breathe deeply
Yes ☐ No ☐	Any other symptoms that you think might be related to lung problems Please list:

SARATOGA HOSPITAL
MEDICAL GROUP
OCCUPATIONAL MEDICINE
2388 ROUTE 9 • MECHANICVILLE • NY • 12118
TEL: (518) 886-5412 • FAX: (518) 899-8069

DOB: Age: Sex:
ADM/SVC Date: Arrival Time:
Loc:

MR#:

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

5. Have you ever had any of the following cardiovascular or heart problems?	
Yes ☐ No ☐	Heart attack
Yes ☐ No ☐	Stroke
Yes ☐ No ☐	Angina
Yes ☐ No ☐	Heart failure
Yes ☐ No ☐	Swelling in your legs or feet (not caused by walking)
Yes ☐ No ☐	Heart arrhythmia (heart beating irregularly)
Yes ☐ No ☐	High blood pressure
Yes ☐ No ☐	Any other heart problem that you've been told about If yes, please list:
6. Have you ever had any of the following cardiovascular or heart symptoms?	
Yes ☐ No ☐	Frequent pain or tightness in your chest
Yes ☐ No ☐	Pain or tightness in your chest during physical activity
Yes ☐ No ☐	Pain or tightness in your chest that interferes with your job
Yes ☐ No ☐	In the past two years, have you noticed your heart skipping or missing a beat?
Yes ☐ No ☐	Heartburn or indigestion that is not related to eating
Yes ☐ No ☐	Any other symptoms that you think may be related to heart or circulation problems. If yes, please list:
7. Do you currently take medication for any of the following problems?	
Yes ☐ No ☐	Breathing or lung problems
Yes ☐ No ☐	Heart trouble
Yes ☐ No ☐	Blood pressure
Yes ☐ No ☐	Seizures (fits)
8. Have you ever used a respirator? Yes ☐ No ☐ **If you've used a respirator, have you ever had any of the following problems?** (proceed to question 9 if you have never used a respirator)	
Yes ☐ No ☐	Eye irritation
Yes ☐ No ☐	Skin allergies or rashes
Yes ☐ No ☐	Anxiety
Yes ☐ No ☐	General weakness or fatigue
Yes ☐ No ☐	Any other problem that interferes with your use of a respirator If yes, please list:
9. Would you like to talk to the health care professional who will review this questionnaire, about your answers to this questionnaire? Yes ☐ No ☐	

Employee's Signature: _____ Date/Time: _____/_____

Clinical Reviewer (print name): _____ Title: _____

Clinical Reviewer (signature): _____ Date/Time _____/_____

(63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998)