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-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 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	

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(2. Continued) Have you ever had any of the following conditions?	
Yes ☐ No ☐	Claustrophobia (fear of closed-in places)
Yes ☐ No ☐	Trouble smelling odors (except when you had a cold)
3. Have you ever had any of the following pulmonary or lung problems:	
Yes ☐ No ☐	Asbestosis
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:

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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 that occurs only when you wear a respirator
Yes ☐ No ☐	Unusual 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)

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Question 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). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

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?	
Yes ☐ No ☐	Wear contact lenses
Yes ☐ No ☐	Wear glasses
Yes ☐ No ☐	Color blind
Yes ☐ No ☐	Any other eye or vision problems: _____
12. 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?	
Yes ☐ No ☐	Difficulty hearing
Yes ☐ No ☐	Wear a hearing aid
Yes ☐ No ☐	Any other hearing or ear problem: _____
14. Have you ever had a back injury?	Yes ☐ No ☐
15. Do you currently have any of the following musculoskeletal problems?	
Yes ☐ No ☐	Weakness in any of your arms, hands, legs or feet
Yes ☐ No ☐	Back pain
Yes ☐ No ☐	Difficulty fully moving your arms and legs
Yes ☐ No ☐	Pain or stiffness when you lean forward or backward at the waist
Yes ☐ No ☐	Difficulty fully moving your head up or down
Yes ☐ No ☐	Difficulty fully moving your head side to side
Yes ☐ No ☐	Difficulty bending at your knees
Yes ☐ No ☐	Difficulty squatting to the ground
Yes ☐ No ☐	Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.
Yes ☐ No ☐	Any other muscle or skeletal problem that interferes with using a respirator: _____

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 feeling 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: _____
   _____
   _____

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3. Have you ever worked with any of the materials, or under any of the conditions listed below:	
Yes ☐ No ☐	Asbestos
Yes ☐ No ☐	Silica (e.g., in sandblasting)
Yes ☐ No ☐	Tungsten/cobalt (e.g., grinding or welding this material)
Yes ☐ No ☐	Beryllium
Yes ☐ No ☐	Aluminum
Yes ☐ No ☐	Coal (for example, mining)
Yes ☐ No ☐	Iron
Yes ☐ No ☐	Tin
Yes ☐ No ☐	Dusty environments
Yes ☐ No ☐	Any other hazardous exposures? 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? Yes ☐ No ☐ **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 ☐ **If yes, name the medications if you know them:** _____	
10. Will you be using any of the following items with your respirator(s)?	
Yes ☐ No ☐	HEPA filters
Yes ☐ No ☐	Canisters (for example, gas masks)
Yes ☐ No ☐	Cartridges
11. How often are you expected to use the respirator(s) (Check "yes" or "no" for all answers that apply to you)?	
Yes ☐ No ☐	Escape only (no rescue)
Yes ☐ No ☐	Emergency rescue only
Yes ☐ No ☐	Less than 2 hours per week
Yes ☐ No ☐	Less than 2 hours per day
Yes ☐ No ☐	2 to 4 hour per day
Yes ☐ No ☐	Over 4 hours per day

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12. During the period you are using the respirator(s), is your work effort:

a) Light (less than 200 kcal per hour) Yes ☐ No ☐

If yes, how long does this period last during the average shift: _____ hrs. _____mins.

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

b) Moderate (200 to 350 kcal per hour) Yes ☐ No ☐

Examples of moderate work effort are: 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.

c) Heavy (above 350 kcal per hour) Yes ☐ No ☐

If yes, how long does this period last during the average shift: shift: _____ hrs. _____mins.

Examples of heavy work are: 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.).

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 respirator(s):

a) Name of the first toxic substance: _____

Estimated maximum exposure per shift: _____

Duration of exposure per shift: _____

b) Name of the second toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

c) Name of the third toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

The name of any 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). _____

_____