## OSHA Respirator Medical Evaluation Questionnaire (Mandatory) (Appendix C to Section 1910.134) Medified Form for Use with NOE Respirator ONLY

Modified Form for Use with N95 Respirator ONLY

(Note 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 (circle one)?: 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.

	rt A - Section 1. (Mandatory) The follo				provided by every	employe	ee who
1.	Today's date:					-	
2.	Your name:					_	
3.	Your age (to nearest year):	4.	Sex:	Male	Female		
5.	Your height: ft in.	6.	Your wei	ght:	lbs.		
7.	Your job title:			_ Service/Ma	ail Code:		
8.	A phone number where you can be read questionnaire (include the area code):						5
9.	The best time to phone you at this num	ber:		A	M PM		
	questionnaire? (circle one): [The hea the occupational health care provid Unit (OHU), at 71977. For questions Safety Service Industrial Hygienist Check the type of respirator you will us nly).	ler ii s reç at 7	n the Aml garding fi 2080.] Ye	oulatory Car t-testing, tra es, See abov	e Service Occupatining or the resport. No	ational irator, o	Health contact
	<ul> <li>b. N/A Other type (for example, half- of contained breathing apparatus)</li> </ul>		II-face pie	ce type, pow	ered-air purifying,	supplie	d-air, self-
12	Have you worn a respirator? (circle one	∍):				Yes	No
	If yes, what type(s):					_	
	rt <b>A - Section 2.</b> (Mandatory) Question o has been selected to use any type of			below must	be answered by e	very em	ployee
1.	Do you currently smoke tobacco or ha	ıve y	you smoke	ed tobacco in	the last month?	Yes	No
2.	Have you ever had any of the following	cor	nditions?				
	<ul><li>a. Seizures (fits)?</li><li>b. Diabetes (sugar disease)?</li><li>c. Allergic reactions that interfere with</li></ul>	you	ır breathin	a?		Yes Yes Yes	No No No

На	e.	Claustrophobia (fear of closed-in places)? Trouble smelling odors? you ever had any of the following pulmonary or lung problems?	Yes Yes	No No3.			
Tia	a. b. c.	Asbestosis Asthma Chronic Bronchitis Emphysema	Yes Yes Yes Yes	No No No No			
		Pneumonia Tuberculosis	Yes Yes	No No			
	g. h. i.	Silicosis Pneumothorax (collapsed lung) Lung Cancer	Yes Yes Yes	No No No			
	j. k.	Broken Ribs Any chest injuries or surgeries	Yes Yes	No No			
	l. _	Any other lung problem that you've been told about	Yes	No			
4.		you currently have any of the following symptoms of pulmonary or lung illness?	V	NI-			
		Shortness of breath Shortness of breath when walking fast on level ground or walking up a slight hill of	Yes or inclin Yes	No e 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. f.	Shortness of breath that interferes with your job	Yes Yes	No No			
	g. h.	Coughing that produces phlegm (thick sputum) Coughing that wakes you early in the morning Coughing that pages mostly when you are bring down	Yes Yes Yes	No No No			
	i. j. k	Coughing that occurs mostly when you are lying down Coughing up blood in the last month Wheezing	Yes Yes	No No			
	I.	Wheezing that interferes with your job Chest pain when you breathe deeply	Yes Yes	No No			
	n.	Any other symptoms that you think may be related to lung problems	Yes	No			
5.	Ha	ave you ever had any of the following cardiovascular or heart problems?					
	b. c.	Heart attack Stroke Angina Heart failure	Yes Yes Yes Yes	No No No No			
	e. f. g.	Heart arrhythmia (heart beating irregularly) High blood pressure	Yes Yes Yes	No No No			
	h.	Any other heart problem that you've been told about	Yes	No			
6.	Ha	Have you ever had any of the following cardiovascular or heart symptoms?					
	a. b.	Frequent pain or tightness in your chest Pain or tightness in your chest during physical activity	Yes Yes	No No			

	<ul> <li>c. Pain or tightness in your chest that interferes with your job</li> <li>d. In the past two years, have you noticed your heart skipping or missing a beat</li> <li>e. Heartburn or indigestion that is not related to eating</li> <li>f. Any other symptom you think may be related to heart or circulation problems</li> </ul>	Yes Yes Yes Yes	No No No No				
7.	Do you currently take medication for any of the following problems?						
	<ul><li>a. Breathing or lung problems</li><li>b. Heart trouble</li><li>c. Blood pressure</li></ul>	Yes Yes Yes	No No No				
	d. Seizures (fits)	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 here and go on to question 9.)						
	a. Eye irritation	Yes	No				
	b. Skin allergies or rashes	Yes	No				
	c. Anxiety	Yes	No				
	<ul><li>d. General weakness or fatigue</li><li>e. Any other problem that interferes with your use of a respirator</li></ul>	Yes Yes	No No				
9.	Would you like to talk to the healthcare professional who will review this questionna answers to this questionnaire (If yes, call Occupational Health Unit at 71977.)	ire aboi Yes	ut your No				
	. If you have questions about the respirator use, workplace hazards or fit-testing rvice Industrial Hygienist at 7-2080.	ıg, cont	tact Safety				
En	nployee Printed Name Signature	<del> </del>					
Da	ite						
	FOR OCCUPATIONAL HEALTH PROVIDER USE ONLY						
1.	Medically cleared to use the N95 respirator (filter mask).						
2.	Medically cleared with restrictions as shown:		<del></del>				
3.	Further evaluation needed.						
4.	Medically not cleared.						
	rinted Name/Signature) cupational Health Provide	Date					