

# **UofL** Respiratory Protection Program

## **Respirator Medical Evaluation Questionnaire**

**OSHA 1910.134 Appendix C**

Place completed questionnaire in an envelope, seal and mark CONFIDENTIAL

Deliver or send via Campus Mail to:

**Respiratory Medical Clearance  
Campus Health Services  
401 East Chestnut Street  
Louisville, KY 40292**

If you have any questions about this medical questionnaire please contact your supervisor or the Respiratory Protection Program Administrator at the Department of Environmental Health and Safety: 852-2961

# UofL Respiratory Protection Program

## Respirator Medical Evaluation Questionnaire

### OSHA 1910.134 Appendix C

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 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.

### Part A: Section 1 Mandatory

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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 Soc. Sec. #: \_\_\_\_\_ Employee ID #: \_\_\_\_\_
4. Your age (to nearest year): \_\_\_\_\_ Birth Date \_\_\_\_\_
5. Sex:  Male  Female
6. Your height: \_\_\_\_\_ ft. \_\_\_\_\_ in.
7. Your weight: \_\_\_\_\_ lbs.
8. Your job title: \_\_\_\_\_
9. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): \_\_\_\_\_
10. The best time to phone you at this number: \_\_\_\_\_
11.  Yes  No Has your employer told you how to contact the health care professional who will review this questionnaire?
12. Check the type of respirator you will use (you can check more than one category):  
 Yes  No N, R, or P disposable respirator (filter-mask, non-cartridge type only)  
 Yes  No Other type (for example, half- or full-facemask type, powered-air purifying, supplied-air, self-contained breathing apparatus)
13.  Yes  No Have you worn a respirator before?  
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").

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Do you <b>currently</b> smoke tobacco, or have you smoked tobacco in the last month?
<b>Question 2 →</b>	2. Have you ever had:
<input type="checkbox"/> Yes <input type="checkbox"/> No	a. Seizures (fits)
<input type="checkbox"/> Yes <input type="checkbox"/> No	b. Diabetes (sugar disease)
<input type="checkbox"/> Yes <input type="checkbox"/> No	c. Allergic reactions that interfere with your breathing
<input type="checkbox"/> Yes <input type="checkbox"/> No	d. Claustrophobia (fear of closed-in places)
<input type="checkbox"/> Yes <input type="checkbox"/> No	e. Trouble smelling odors
<b>Question 3 →</b>	3. Have you ever had any of the following pulmonary or lung problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No	a. Asbestosis
<input type="checkbox"/> Yes <input type="checkbox"/> No	b. Asthma
<input type="checkbox"/> Yes <input type="checkbox"/> No	c. Chronic bronchitis
<input type="checkbox"/> Yes <input type="checkbox"/> No	d. Emphysema
<input type="checkbox"/> Yes <input type="checkbox"/> No	e. Pneumonia
<input type="checkbox"/> Yes <input type="checkbox"/> No	f. Tuberculosis
<input type="checkbox"/> Yes <input type="checkbox"/> No	g. Silicosis
<input type="checkbox"/> Yes <input type="checkbox"/> No	h. Pneumothorax (collapsed lung)
<input type="checkbox"/> Yes <input type="checkbox"/> No	i. Lung cancer
<input type="checkbox"/> Yes <input type="checkbox"/> No	j. Broken ribs
<input type="checkbox"/> Yes <input type="checkbox"/> No	k. Any chest injuries or surgeries
<input type="checkbox"/> Yes <input type="checkbox"/> No	l. Any other lung problem that you've been told about
<b>Question 4 →</b>	4. Do you <b>currently</b> have any of the following symptoms of pulmonary or lung illness?
<input type="checkbox"/> Yes <input type="checkbox"/> No	a. Shortness of breath
<input type="checkbox"/> Yes <input type="checkbox"/> No	b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
<input type="checkbox"/> Yes <input type="checkbox"/> No	c. Shortness of breath when walking with other people at an ordinary pace on level ground
<input type="checkbox"/> Yes <input type="checkbox"/> No	d. Have to stop for breath when walking at your own pace on level ground
<input type="checkbox"/> Yes <input type="checkbox"/> No	e. Shortness of breath when washing or dressing yourself
<input type="checkbox"/> Yes <input type="checkbox"/> No	f. Shortness of breath that interferes with your job
<input type="checkbox"/> Yes <input type="checkbox"/> No	g. Coughing that produces phlegm (thick sputum)

<input type="checkbox"/> Yes <input type="checkbox"/> No	h. Coughing that wakes you early in the morning
<input type="checkbox"/> Yes <input type="checkbox"/> No	i. Coughing that occurs mostly when you are lying down
<input type="checkbox"/> Yes <input type="checkbox"/> No	j. Coughing up blood in the last month
<input type="checkbox"/> Yes <input type="checkbox"/> No	k. Wheezing
<input type="checkbox"/> Yes <input type="checkbox"/> No	l. Wheezing that interferes with your job
<input type="checkbox"/> Yes <input type="checkbox"/> No	m. Chest pain when you breathe deeply
<input type="checkbox"/> Yes <input type="checkbox"/> No	m. Any other symptoms that you think may be related to lung problems
<b>Question 5 →</b>	5. Have you <b>ever had</b> any of the following cardiovascular or heart problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No	a. Heart attack
<input type="checkbox"/> Yes <input type="checkbox"/> No	b. Stroke
<input type="checkbox"/> Yes <input type="checkbox"/> No	c. Angina
<input type="checkbox"/> Yes <input type="checkbox"/> No	d. Heart failure
<input type="checkbox"/> Yes <input type="checkbox"/> No	e. Swelling in your legs or feet (not caused by walking)
<input type="checkbox"/> Yes <input type="checkbox"/> No	f. Heart arrhythmia (heart beating irregularly)
<input type="checkbox"/> Yes <input type="checkbox"/> No	g. High blood pressure
<input type="checkbox"/> Yes <input type="checkbox"/> No	h. Any other heart problem that you've been told about
<b>Question 6 →</b>	6. Have you <b>ever had</b> any of the following cardiovascular or heart symptoms?
<input type="checkbox"/> Yes <input type="checkbox"/> No	a. Frequent pain or tightness in your chest
<input type="checkbox"/> Yes <input type="checkbox"/> No	b. Pain or tightness in your chest during physical activity
<input type="checkbox"/> Yes <input type="checkbox"/> No	c. Pain or tightness in your chest that interferes with your job
<input type="checkbox"/> Yes <input type="checkbox"/> No	d. In the past two years, have you noticed your heart skipping or missing a beat
<input type="checkbox"/> Yes <input type="checkbox"/> No	e. Heartburn or indigestion that is not related to eating
<input type="checkbox"/> Yes <input type="checkbox"/> No	f. Any other symptoms that you think may be related to heart or circulation problems
<b>Question 7 →</b>	7. Do you <b>currently</b> take medication for any of the following problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No	a. Breathing or lung problems
<input type="checkbox"/> Yes <input type="checkbox"/> No	b. Heart trouble
<input type="checkbox"/> Yes <input type="checkbox"/> No	c. Blood pressure
<input type="checkbox"/> Yes <input type="checkbox"/> No	d. Seizures (fits)
<b>Question 8 →</b>	8. If you've used a respirator, have you <b>ever had</b> any of the following problems? (If you've never used a respirator go to question 9:)
<input type="checkbox"/> Yes <input type="checkbox"/> No	a. Eye irritation
<input type="checkbox"/> Yes <input type="checkbox"/> No	b. Skin allergies or rashes
<input type="checkbox"/> Yes <input type="checkbox"/> No	c. Anxiety

<input type="checkbox"/> Yes <input type="checkbox"/> No	d. General weakness or fatigue
<input type="checkbox"/> Yes <input type="checkbox"/> No	e. Any other problem that interferes with your use of a respirator
<p>Questions 9 to 14 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).</p> <p>For employees who have been selected to use other types of respirators, answering these questions is <b>voluntary</b>.</p>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Have you <b>ever lost</b> vision in either eye (temporarily or permanently)?
<b>Question 10</b> →	10. Do you <b>currently</b> have any of the following vision problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No	a. Wear contact lenses
<input type="checkbox"/> Yes <input type="checkbox"/> No	b. Wear glasses
<input type="checkbox"/> Yes <input type="checkbox"/> No	c. Color blindness
<input type="checkbox"/> Yes <input type="checkbox"/> No	d. Any other eye or vision problem
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Have you <b>ever had</b> an injury to your ears, including a broken ear drum?
<b>Question 11</b> →	12. Do you <b>currently</b> have any of the following hearing problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No	a. Difficulty hearing
<input type="checkbox"/> Yes <input type="checkbox"/> No	b. Wear a hearing aid
<input type="checkbox"/> Yes <input type="checkbox"/> No	c. Any other hearing or ear problem
<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Have you <b>ever had</b> a back injury?
<b>Question 12</b> →	14. Do you <b>currently</b> have any of the following musculoskeletal problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No	a. Weakness in any of your arms, hands, legs, or feet
<input type="checkbox"/> Yes <input type="checkbox"/> No	b. Back pain
<input type="checkbox"/> Yes <input type="checkbox"/> No	c. Difficulty fully moving your arms and legs
<input type="checkbox"/> Yes <input type="checkbox"/> No	d. Pain or stiffness when you lean forward or backward at the waist
<input type="checkbox"/> Yes <input type="checkbox"/> No	e. Difficulty fully moving your head up or down
<input type="checkbox"/> Yes <input type="checkbox"/> No	f. Difficulty fully moving your head side to side
<input type="checkbox"/> Yes <input type="checkbox"/> No	g. Difficulty bending at your knees
<input type="checkbox"/> Yes <input type="checkbox"/> No	h. Difficulty squatting to the ground
<input type="checkbox"/> Yes <input type="checkbox"/> No	i. Climbing a flight of stairs or a ladder carrying more than 25 lbs
<input type="checkbox"/> Yes <input type="checkbox"/> No	i. 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 health care professional who will review the questionnaire.

<b>Question 1 →</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	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?						
If no go to #2 If Yes, go to 1a →	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	1a. If " <b>yes</b> ," do you have feelings of dizziness, shortness of breath, pounding in your chest or other symptoms when you're working under these conditions?						
<b>Question 2 →</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	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?						
If Yes then → If no go to #3	<p style="text-align: center;">If "<b>yes</b>," name the chemicals if you know them:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1. _____</td> <td style="width: 50%;">4. _____</td> </tr> <tr> <td>2. _____</td> <td>5. _____</td> </tr> <tr> <td>3. _____</td> <td>6. _____</td> </tr> </table>		1. _____	4. _____	2. _____	5. _____	3. _____	6. _____
1. _____	4. _____							
2. _____	5. _____							
3. _____	6. _____							
<b>Question 3 →</b>	Have you ever worked with any of the materials, or under any of the conditions, listed below?							
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	a. Asbestos							
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	b. Silica (e.g., in sandblasting)							
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	c. Tungsten/cobalt (e.g., grinding or welding this material)							
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	d. Beryllium							
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	e. Aluminum							
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	f. Coal (for example, mining)							
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	g. Iron							
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	h. Tin							
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	i. Dusty environments							
If Yes to 3a – i, then → If no go to #4	If " <b>yes</b> ," describe these exposures:							
<b>Question 4 →</b>	4. List any second jobs or side businesses you have:							
<b>Question 5 →</b>	5. List your previous occupations:							
<b>Question 6 →</b>	6. List your current and previous hobbies							
<b>Question 7 →</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	7. Have you been in the military services?						
If Yes then → If no go to #8	<p style="text-align: center;">a. If "<b>yes</b>," were you exposed to biological or chemical agents (either in training or combat)? Please list any agents that you were exposed to:</p>							

Question 8→	<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Have you ever worked on a HAZMAT team?
Question 9→	<input type="checkbox"/> Yes <input type="checkbox"/> 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)
If Yes then → If no go to #10	If "yes," name the medications if you know them	
Question 10→	10. Will you be using any of the following items with your respirator(s)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	a. HEPA Filters	
<input type="checkbox"/> Yes <input type="checkbox"/> No	b. Canisters (for example, gas masks)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	c. Cartridges	
Question 11→	11. How often are you expected to use the respirator(s)? (check "yes" or "no" for all answers that apply to you)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	a. Escape only (no rescue)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	b. Emergency rescue only	
<input type="checkbox"/> Yes <input type="checkbox"/> No	c. Less than 5 hours <b>per week</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	d. Less than 2 hours <b>per day</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	e. 2 to 4 hours per day	
<input type="checkbox"/> Yes <input type="checkbox"/> No	f. Over 4 hours per day	
Question 12→	12. During the period you are using the respirator(s), is your work effort:	Examples:
<input type="checkbox"/> Yes <input type="checkbox"/> No	12a. Light (less than 200 kcal per hour)	<b>sitting</b> while writing, typing, drafting, or performing light assembly work; or <b>standing</b> while operating a drill press (1-3 lbs.) or controlling machines.
If Yes then → If no go to 12. b	How long does this period last during the average shift: ____ hrs. ____ min	
<input type="checkbox"/> Yes <input type="checkbox"/> No	12b. Moderate (200 to 350 kcal per hour)	are <b>sitting</b> while nailing or filing; <b>driving</b> a truck or bus in urban traffic; <b>standing</b> while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; <b>walking</b> on a level surface about 2 mph or down a 5-degree grade about 3 mph; or <b>pushing</b> a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.
If Yes above then → If no go to 12. c	How long does this period last during the average shift: ____ hrs. ____ min	
<input type="checkbox"/> Yes <input type="checkbox"/> No	12c. Heavy (above 350 kcal per hour)	<b>lifting</b> a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; <b>shoveling</b> ; <b>standing</b> while bricklaying or chipping castings; <b>walking</b> up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).
If Yes above then → If no go to 13	How long does this period last during the average shift: ____ hrs. ____ min	
Question 13→	<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator?
If Yes above then → If no go to 14	13a. Describe this protective clothing and/or equipment:	

Question 14→	<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Will you be working under hot conditions (temperature exceeding 77 degrees F)
Question 15→	<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Will you be working under humid conditions
Question 16→	16. Describe the work you'll be doing while you're using your respirator(s):	
Question 17→	17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):	
Question 18→	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):	
	Substance	Est. Maximum Exposure/Shift
		Duration per Shift (Hours)
	The name of any other toxic substances that you'll be exposed to while using your respirator:	
Question 19→	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, security)	
Question 20→	<input type="checkbox"/> Yes <input type="checkbox"/> No	Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?
Employee Signature: _____ Date: _____		

Please deliver or send completed questionnaire in a sealed envelope addressed via CAMPUS mail to:

Respiratory Evaluation Program  
 Campus Health Services  
 401 East Chestnut Street Suite 110  
 Louisville, KY 40292

If you have any questions about this medical questionnaire please contact your supervisor or the Respiratory Protection Program Administrator at the Department of Environmental Health and Safety: 852-2961