ACADIANA CENTER

2501 West Pinhook Road; Lafayette, LA 70508
Phone (337) 269-0136 Fax (337) 233-8525

Mandatory OSHA Respirator Medical Evaluation Questionnaire Standard – 29 CFR 1910.134; Appendix C

Name_____ **Date**_____

Date of Birth_____ **Age**_____ **Sex** ☐ **Male** ☐**Female**

Height _____**ft** _____**in.** **Weight** _____**lbs.** **Job Title** _____

To the employee: Can you read? (Circle One) Yes No

Completion of this Respirator Medical Evaluation Questionnaire is mandatory according to OSHA Section 1910.134 for any employee/potential employee who will be required to wear a respirator as part of their job. ***This questionnaire is part of the medical evaluation which must be completed prior to fit testing and initial use of a respirator.*** It is very important that all questions are answered truthfully and completely. Answer each question requiring a yes or no answer by marking an X on the appropriate line.

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 this 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 in their job. Please provide a phone number where you can be reached by the health care professional who will review this questionnaire.

(_____) - _____ - _____. The best time to phone you at this number is _____

YES **NO**

_____ _____ Has your employer told you how to contact the health care professional who will review this questionnaire?

_____ _____ Have you worn a respirator? If Yes, what type(s)?_____

_____

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).

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.

YES NO

_____ _____ 1.Do you *currently* smoke, or have you smoked, tobacco in the last month?
*If yes, please explain*_____

YES NO

2. Have you *ever had* any of the following conditions?

_____ _____ Seizures (fits)
_____ _____ Diabetes (sugar disease)
_____ _____ Allergic reactions that interfere with your breathing
_____ _____ Claustrophobia (fear of closed-in places)
_____ _____ Trouble smelling odors
If yes, please explain _____

YES NO

3. Have you *ever had* any of the following pulmonary or lung problems?

_____ _____ Asbestosis
_____ _____ Asthma
_____ _____ Chronic bronchitis/Emphysema
_____ _____ Pneumonia
_____ _____ Tuberculosis
_____ _____ Silicosis
_____ _____ Pneumothorax (collapsed lung)
_____ _____ Lung cancer
_____ _____ Broken ribs
_____ _____ Any chest injuries or surgeries
_____ _____ Any other lung problem that you've been told about
If yes, please explain _____

YES NO

4. Do you *currently* have any of the symptoms of pulmonary/lung illness?

_____ _____ Shortness of breath
_____ _____ Shortness of breath when walking fast on level ground or up a slight hill/incline
_____ _____ Shortness of breath when walking with others at an ordinary pace/level ground
_____ _____ Have to stop for breath when walking at your own pace on level ground
_____ _____ Shortness of breath when washing or dressing yourself
_____ _____ Shortness of breath that interferes with your job
_____ _____ Coughing that produces phlegm (thick sputum)
_____ _____ Coughing that wakes you early in the morning
_____ _____ Coughing that occurs mostly when you are lying down
_____ _____ Coughing up blood in the last month
_____ _____ Wheezing
_____ _____ Wheezing that interferes with your job
_____ _____ Chest pain when you breathe deeply
_____ _____ Any other symptoms that you think may be related to lung problems
If yes, please explain _____

YES NO

5. Have you *ever had* any of the following cardiovascular or heart problems?

_____ _____ Heart attack
_____ _____ Stroke
_____ _____ Angina
_____ _____ Heart failure
If yes, please explain _____

Patient Initials _____

YES NO

_____ _____ Swelling in your legs or feet (not caused by walking)
_____ _____ Heart arrhythmia (heart beating irregularly)
_____ _____ High blood pressure
_____ _____ Any other heart problem that you've been told about
If yes, please explain _____

YES NO

6. Have you *ever had* any of the following cardiovascular or heart symptoms?

_____ _____ Frequent pain or tightness in your chest
_____ _____ Pain or tightness in your chest during physical activity
_____ _____ Pain or tightness in your chest that interferes with your job
_____ _____ In the past two years, have you noticed your heart skipping or missing a beat
_____ _____ Heartburn or indigestion that is not related to eating
_____ _____ Any other symptoms that you think may be related to heart/circulation problems
If yes, please explain _____

YES NO

7. Do you *currently* take medication for any of the following problems?

_____ _____ Breathing or lung problems
_____ _____ Heart trouble
_____ _____ Blood pressure
_____ _____ Seizures (fits)
If yes, please explain _____
_____ If you've never used a respirator, mark this place and go to question 9.

YES NO

8. If you've used a respirator, have you *ever had* any of the following problems?

_____ _____ Eye irritation
_____ _____ Skin allergies or rashes
_____ _____ Anxiety
_____ _____ General weakness or fatigue
_____ _____ Any other problem that interferes with your use of a respirator
*If yes, please explain*_____

YES NO

_____ _____ 9. Would you like to talk to the licensed health care provider who will review this questionnaire about your answers to this questionnaire?

Questions 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 will use other types of respirators, answering these questions is voluntary.

YES NO

_____ _____ 10. Have you *ever lost* vision in either eye (temporarily or permanently)*?*
If yes, please explain _____

YES NO

11. Do you *currently* have any of the following vision problems?

_____ _____ Wear contact lenses
_____ _____ Wear glasses
_____ _____ Color blind
_____ _____ Any other eye or vision problem
If yes, please explain _____

YES NO

_____ _____12.Have you *ever had* an injury to your ears, including a broken ear drum?
If yes, please explain _____

Patient Initials _____

YES NO

13. Do you *currently* have any of the following hearing problems?

_____ _____ Difficulty hearing
_____ _____ Wear a hearing aid
_____ _____ Any other hearing or ear problem
If yes, please explain _____

YES NO

_____ _____14. Have you *ever had* a back injury?
If yes, please explain _____
_____

YES NO

15. Do you *currently* have any of the following musculoskeletal problems?

_____ _____ Weakness in any of your arms, hands, legs, or feet
_____ _____ Back pain
_____ _____ Difficulty fully moving your arms and legs
_____ _____ Pain or stiffness when you lean forward or backward at the waist
_____ _____ Difficulty fully moving your head up or down
_____ _____ Difficulty fully moving your head side to side
_____ _____ Difficulty bending at your knees
_____ _____ Difficulty squatting to the ground
_____ _____ Climbing a flight of stairs or a ladder carrying more than 25 lbs
_____ _____ Any other muscle or skeletal problem that interferes with using a respirator
If yes, please explain _____

Patient Signature_____ Date_____

Blood Pressure _____ Heart Rate _____

Comments from Licensed Healthcare Provider Reviewing this Questionnaire

_____
_____
_____
_____
_____

☐ No Medical Record at Acadiana Center ☐ Medical Record at Acadiana Center Reviewed

Medical Provider

☐ G. Gidman, MD ☐ F. Baniewicz, Jr MD ☐ C. Hernandez, MD ☐ A. O'Quin, ANP ☐ Other

_____
Signature/Date

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OSHA Respirator Medical Clearance Evaluation
Licensed Healthcare Provider Statement

Name _____ **Date** _____

Date of Birth/Age _____ **Job Title** _____

The above named individual has completed a medical evaluation as outlined by OSHA in the respiratory standard 1910.134. This evaluation consisted of the following components:

☐ Mandatory OSHA Questionnaire (1910.134 – Appendix C)
☐ Comprehensive Medical/Surgical History & Physical Examination
☐ Pulmonary Function Testing ☐ Chest X-Ray
☐ Electrocardiogram ☐ Exercise Treadmill Testing
☐ Focused Medical Interview
☐ Focused Medical Examination
☐ Focused Phone Interview
☐ Other_____

Based on the above evaluation, I have determined:

☐ Medically Qualified to Wear a: ☐ Respirator ☐ Self-Contained Breathing Apparatus
☐ Escape Only ☐ Positive Pressure ☐ Time Limited (specify) _____

☐ Not Medically Qualified to Wear Any Type of Respirator (specify) _____

☐ I Recommend Follow-up Medical Evaluations on a Yearly Basis.

Medical Provider

☐ G. Gidman, MD ☐ F. Baniewicz, Jr MD ☐ C. Hernandez, MD ☐ A. O'Quin, ANP ☐ Other

_____
Signature of Healthcare Provider/Date

I have been informed of all evaluation findings:

☐ Patient Not Present for Review
☐ Patient Can Not Be Contacted for Review

_____
Signature of Employee/Applicant

****

Qualitative Fit Testing

☐ Performed ☐ Not Performed
☐ Adequate Fit Obtained ☐ Adequate Fit NOT Obtained