1925 West John Carpenter Frwy Suite 550
Irving, TX 75063
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800-896-5530Fax

OSHA Respirator Medical Evaluation CFR 29 1910:134

To the Employee

Can you read: **( ) Yes ( ) No**

1. Today's date: _____

2. Your name: _____

3. Your age (to nearest year) _____

4. Sex: ( ) 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 reviews this questionnaire:

_____

9. The best time to call you at this number: _____

10. Has the employer told you how to contact the health care professional who will review this questionnaire (including area code)

_____

11 Which type of respirator will you be using while on the job?

( ) _____N, R, or P disposable respirator (filter mask, non-cartridge type only)

( ) Other style please note:

( ) Half face ( ) Powered-air purifying
( ) Full face ( ) Supplied air
( ) SCBA – Self-contained Breathing Apparatus

12. Have you ever worn or used a respirator?

( ) Yes
( ) No

If yes what type? _____

PDS Tech

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Part A Section 2 (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type respirator.

1. **Do you currently smoke tobacco or have you smoked tobacco in the last month?**

( ) Yes
( ) No

2. **Have you suffered from the following conditions?**

Seizures (Fits)	( ) Yes ( ) No
Diabetes (Blood or urine sugar)	( ) Yes ( ) No
Allergic reaction that interferes with your breathing	( ) Yes ( ) No
Claustrophobia (fear of crowded or closed in spaces)	( ) Yes ( ) No
Trouble smelling odors	( ) Yes ( ) No

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

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	( ) Yes ( ) No
Any other lung problem that you've been told about	( ) Yes ( ) No

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

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 a 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 laying down	( ) Yes ( ) No
Coughing up blood in the last month	( ) Yes ( ) No
Wheezing	( ) Yes ( ) No
Wheezing that interferes with your job	( ) Yes ( ) No
Chest pains when you breathe deeply	( ) Yes ( ) No
Any other symptoms that you think may be related to a lung problem	( ) Yes ( ) No

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

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 irregular)	( ) Yes ( ) No
High blood pressure	( ) Yes ( ) No
Any other heart problem that you've been told about	( ) Yes ( ) No

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

Frequent pain 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	( ) Yes ( ) N o

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

Breathing or lung problems	( ) Yes ( ) No
Heart trouble	( ) Yes ( ) No
Blood pressure	( ) Yes ( ) No
Seizures (fits)	( ) Yes ( ) No

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

Eye irritation	( ) Yes ( ) No
Skin allergies or rashes	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No
General weakness or fatigue	( ) Yes ( ) No
Any problems that interfere with your use of a respirator	( ) Yes ( ) No

9. **Would you like to talk to the health care professional who will review this questionnaire about your answers to the questions?**

( ) Yes
( ) No

Questions 10-15 on the next page must be answered by every employee who has been selected to use either full-face respirator or a self-contained breathing apparatus (SCBA). For employees who are selected to use other types of respirators, answering these questions is voluntary

10. **Have you ever lost vision in either eye (temporary or permanently)?**

( ) Yes
( ) No

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

Wear contact lenses	( ) Yes ( ) No
Wear glasses	( ) Yes ( ) No
Color blind	( ) Yes ( ) No
Any other eye or vision problem	( ) Yes ( ) No

12. **Have you ever had injury to your ears including a broken ear drum?**

( ) Yes
( ) No

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

Difficulty hearing	( ) Yes ( ) No
Wear a hearing aid	( ) Yes ( ) No
Any other hearing or ear problems	( ) Yes ( ) No

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14. **Have you ever had a back injury?**

( ) Yes
( ) No

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

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 and down	( ) Yes ( ) No
Difficulty moving your head from side to side	( ) Yes ( ) No
Difficulty bending at your knees	( ) Yes ( ) No
Difficulty squatting to the ground	( ) Yes ( ) No
Climbing a flight of stairs or a ladder carrying more than 25 pounds	( ) Yes ( ) No
Any other muscle or skeletal problem that interferes with using a respirator	( ) Yes ( ) No

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.

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 feelings of dizziness, shortness of breath, pounding in your chest or other symptoms when you are working under these conditions?

( ) Yes
( ) No

2. **At home have you ever been exposed to hazardous solvents, hazardous airborne chemicals (gasses, fumes, dust) or have you come into skin contact with hazardous chemicals?**

( ) Yes
( ) No

3. **Have you ever worked with any of the materials or under any of the conditions listed below?**

Asbestos	( ) Yes ( ) No
Silica (found in sandblasting)	( ) Yes ( ) No
Tungsten Cobalt/ cobalt (found in grinding or welding material)	( ) Yes ( ) No
Beryllium	( ) Yes ( ) No
Aluminum	( ) Yes ( ) No
Coal (for example miming)	( ) Yes ( ) No
Iron	( ) Yes ( ) No
Tin	( ) Yes ( ) No
Dusty Environments	( ) Yes ( ) No
Any other hazardous exposures	( ) Yes ( ) No

If yes please describe the exposures: _____

_____

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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 service?**

( ) Yes
( ) No

8. **Have you ever worked on a HAZMAT team?**

( ) Yes
( ) No

9. **Other than medications for breathing or lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any other reason (including over-the-counter medications)?**

( ) Yes
( ) No

If yes name the medications: _____

_____

10. **Will you be using any of the following items with your respirator?**

HEPA Filters	( ) Yes ( ) No
Canisters (for example gas masks)	( ) Yes ( ) No
Cartridges	( ) Yes ( ) No

11. **How often are you expected to use the respirator?**

Escape only (no rescue)	( ) Yes ( ) No
Emergency rescue only	( ) Yes ( ) No
Less than 5 hours a week	( ) Yes ( ) No
Less than 2 hours per day	( ) Yes ( ) No
2 to 4 times a day	( ) Yes ( ) No
Over 4 hours a day	( ) Yes ( ) No

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

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

If yes how long does this period last during an average shift: _____ hour's _____mins.

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

Moderate (above 350kcal per hour) ( ) Yes ( ) No

If yes how long does this period last during an average shift: _____ hours _____ mins

Examples of a 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 pounds) at waist 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 pounds) on a level surface.

Heavy (above 350 Kcal per hour) ( ) Yes ( ) No

If yes how long does this period last during an average shift: _____ hours _____ mins

Examples of heavy work are lifting a heavy load (about 50 pounds) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while brick laying or chipping castings; walking up an 8 degree grade about 2 mph; climbing stairs with a heavy load (about 50 pounds).

13. **Will you be wearing protective clothing and/or equipment (other than respirator) when using your respirator?**

( ) Yes
( ) No

14. **Will you be working under "hot" conditions (ambient temperature that exceeds 77 degree F)?**

( ) Yes
( ) No

15. **Will you be working under humid conditions?**

( ) Yes
( ) No

16. **Describe the work that you will required to complete while wearing respirator:** _____

_____

_____

_____

17. **Describe any special or hazardous conditions you might encounter when you are using you respirator (examples: gases, confined spaces):**

_____

_____

_____

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18. **Provide the following information (if you know it) for each of the toxic substances that you will be exposed to while using your respirator:**

(1) Name of toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

(2) Name of toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

(3) Name of toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

(4) Name of toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

19. **Describe any special responsibilities you will have while using your respirator that may affect the safety and well-being of others:**

_____

_____

_____

_____

To the best of my knowledge the information I have provided is true and accurate.

_____ _____

(Employee Name) **(Date)**

_____

(Employee Signature)