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).

<u>Part A - Section 2 (Mandatory)</u> – Q<u>uestions 1 through 9</u> below must be answered by every employee who has been selected to use any type of respirator.

<u>YES</u> <u>NO</u>
_____ _____ 1.Do you *currently* smoke, or have you smoked, tobacco in the last month?
*If yes, please explain*____

<u>YES</u> <u>NO</u>
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 ____

<u>YES</u> <u>NO</u>
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 ____

<u>YES</u> <u>NO</u>
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 ____

<u>YES</u> <u>NO</u>
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?

Patient Signature____________________________ Date_________________________________

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 ☐ K. Knecht, ANP ☐ R. Havlik, FNP

____

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) ☐ Focused Medical Interview
☐ Comprehensive Medical/Surgical History & Physical Examination ☐ Focused Medical Examination
☐ Pulmonary Function Testing ☐ Chest X-Ray ☐ Focused Phone Interview
☐ Electrocardiogram ☐ Exercise Treadmill Testing ☐ 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 ☐ K. Knecht, ANP ☐ R. Havlik, FNP

____
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