OSHA 29 CFR 1910.134 RESPIRATORY PROTECTION PROGRAM APPENDIX C—QUESTIONNAIRE (MANDATORY)

To the employee: Answers to questions in Section 1 and to question 9 in Section 2 of Part A do not require a medical examination.

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 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. 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: ___________________________ Student/Employee Id #: ______________________
3. Your age: __________________________
4. Sex (circle one): Male / Female Date of birth: ______________________
5. Your height: _____ ft. _____ in.
7. Your job title: __________________ Dept. __________________
8. Phone number where you can be reached by the health care professional who reviews this questionnaire (include area code): (___) ___-____-_______
9. The best time to phone you at this number: __________________________
10. Has your employer told you how to contact the health care professional who will review this questionnaire? Yes [ ] No [ ]
11. Check the type of respirator you will use (can check more than one category):
   a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only)
   b. _____ other type (half or full-facepiece type, powered air purifying, supplied air, self contained breathing apparatus)
12. Have you worn a respirator? Yes [ ] No [ ]
    if yes, what type(s): ________________________________

Part A. Section 2. 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”).

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes [ ] No [ ]
   If “yes,” indicate: How many packs a day do you smoke: < ¼ ¼ ½ ¾ 1 2 3 4
   How many years have you smoked: __________________________?

2. Have you ever had any of the following conditions?
   a. Seizures: Yes [ ] No [ ]
      If you answered “yes,” when was the last time
   b. Diabetes (sugar disease): Yes [ ] No [ ]
      If “yes,” do you have spells of hypoglycemia (low blood sugar): Yes [ ] No [ ]
   c. Allergic reactions that interfere with your breathing: Yes [ ] No [ ]
      If “yes,” did you have problems in the past year:
   d. Claustrophobia (fear of closed-in places): Yes [ ] No [ ]
      If “yes,” did you have problems in the past year:
   e. Trouble smelling odors: Yes [ ] No [ ]
3. Have you ever had any of the following pulmonary or lung problems?

   a. Asbestosis: 
      Yes □ No □
   b. Asthma: 
      Yes □ No □
   c. Chronic bronchitis: 
      Yes □ No □
   d. Emphysema: 
      Yes □ No □
   e. Pneumonia: 
      Yes □ No □
   f. Tuberculosis: 
      Yes □ No □
   g. Silicosis: 
      Yes □ No □
   h. Pneumothorax (collapsed lung): 
      Yes □ No □
   i. Lung cancer: 
      Yes □ No □
   j. Broken ribs: 
      Yes □ No □
   k. Any chest injuries or surgeries: 
      Yes □ No □
   l. Any other lung problem that you have been told about: 
      Yes □ No □

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

   a. Shortness of breath: 
      Yes □ No □
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: 
      Yes □ 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. Shortness of breath when washing or dressing yourself: 
      Yes □ No □
   f. Shortness of breath that interferes with your job: 
      Yes □ No □
   g. Coughing that produces phlegm (thick sputum): 
      Yes □ No □
   h. Coughing that wakes you early in the morning: 
      Yes □ No □
   i. Coughing that occurs mostly when you are lying down: 
      Yes □ No □
   j. Coughing up blood in the last month: 
      Yes □ No □
   k. Wheezing: 
      Yes □ No □
   l. Wheezing that interferes with your job: 
      Yes □ No □
   m. Chest pain when you breathe deeply: 
      Yes □ No □
   n. Any other symptom that you think may be related to lung problems: 
      Yes □ No □

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

   a. Heart attack: 
      Yes □ No □
   b. Stroke: 
      Yes □ No □
   c. Angina: 
      Yes □ No □
   d. Heart failure: 
      Yes □ No □
   e. Swelling in your legs or feet (not caused by walking): 
      Yes □ No □
   f. Heart arrhythmia (heart beating irregularly): 
      Yes □ No □
   g. High blood pressure: 
      Yes □ No □
   h. Any other heart problem that you’ve been told about: 
      Yes □ No □

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

   a. Frequent pain or tightness in your chest: 
      Yes □ No □
   b. Pain or tightness in your chest during physical activity: 
      Yes □ No □
c. Pain or tightness in your chest that interferes with your job: Yes ☐ No ☐

d. In the past two years, have you noticed your heart skipping or missing a beat: Yes ☐ No ☐

e. Heartburn or indigestion that is not related to eating: Yes ☐ No ☐

f. Any other symptoms that you think may be related to heart or circulation problems: Yes ☐ No ☐

Circle the “yes” answers that were in the last 6 months: a b c d e f

7. Do you currently take medication for any of the following problems?
   a. Breathing or lung problems: Yes ☐ No ☐
   b. Heart problems: Yes ☐ No ☐
   c. Blood pressure: Yes ☐ No ☐
   d. Seizures: Yes ☐ No ☐

   List the medications:

8. If you’ve used a respirator, have you ever had any of the following problems?
   (If you’ve never used a respirator, check the following space ___ and go to question 9.)
   a. Eye irritation: Yes ☐ No ☐
   b. Skin allergies or rashes: Yes ☐ No ☐
   c. Anxiety: Yes ☐ No ☐
   d. General weakness or fatigue: Yes ☐ No ☐
   e. Any other problem that interferes with your use of a respirator: Yes ☐ No ☐

   Circle the “yes” answers that were in the last 6 months: a b c d e f

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? Yes ☐ No ☐

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 have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you ever lost vision in either eye (temporarily or permanently)? Yes ☐ No ☐

11. Do you currently have any of the following vision problems?
   a. Wear contact lenses: Yes ☐ No ☐
   b. Wear glasses: Yes ☐ No ☐
   c. Color blind: Yes ☐ No ☐
   d. Any other eye or vision problem: Yes ☐ No ☐

12. Have you ever had an injury to your ears, including a broken eardrum? Yes ☐ No ☐

13. Do you currently have any of the hearing problems?
   a. Difficulty hearing: Yes ☐ No ☐
   b. Wear a hearing aid: Yes ☐ No ☐
   c. Any other hearing or ear problems: Yes ☐ No ☐

14. Have you ever had a back injury: Yes ☐ No ☐

15. Do you currently have any of the following musculoskeletal problems?
   a. Weakness in any of your arms, hands, legs, or feet: Yes ☐ No ☐
      If “yes,” specify which part: __________________________
   b. Back pain: Yes ☐ No ☐
      If “yes,” specify where it hurts: ________________________, how often: ____________
      Do you take medication: Yes ☐ No ☐

   If “yes,” name the medicine(s) __________________________

   Have you had surgery on your back: Yes ☐ No ☐

   c. Difficulty fully moving your arms and legs: Yes ☐ No ☐
      If “yes,” specify which part: __________________________

   d. Pain or stiffness when you lean forward or backward at the waist: Yes ☐ No ☐

   e. Difficulty moving your head up or down: Yes ☐ No ☐

   f. Difficulty moving your head side to side: Yes ☐ No ☐
g. Difficulty bending at your knees: Yes □ No □

h. Difficulty squatting to the ground: Yes □ No □

i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.: Yes □ No □

j. 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 (>5000 ft) 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, and pounding in your chest, or other symptoms when you're working under these conditions: Yes □ No □

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (for example: gases, fumes, dust), or have you come into skin contact with hazardous chemicals? Yes □ No □
   If "yes," name the chemicals if you know them:

3. Have you ever worked with any of the materials, or under any conditions, listed below?
   a. Asbestos: Yes □ No □
   b. Silica (for example: sandblasting): Yes □ No □
   c. Tungsten/ cobalt (for example: grinding or welding this material): Yes □ No □
   d. Beryllium: Yes □ No □
   e. Aluminum: Yes □ No □
   f. Coal (for example, mining): Yes □ No □
   g. Iron: Yes □ No □
   h. Tin: Yes □ No □
   i. Dusty environments: Yes □ No □
   j. Any other hazardous exposures: Yes □ No □
      If "yes," describe these exposures:

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 services? Yes □ No □
   If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes □ No □

8. Have you ever worked on a HAZMAT team? Yes □ 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)? Yes □ No □

10. Will you be using any of the following items with respirator(s)?
    a. HEPA filters: Yes □ No □
    b. Canisters (for example, gas masks): Yes □ No □
    c. Cartridges: Yes □ No □

11. How often are you expected to use the respirator(s)?
    a. Escape only (no rescue): Yes □ No □
    b. Emergency rescue only: Yes □ No □
    c. Time used [check the best answer]:
        [ ] Less than 5 hours per week
        [ ] Less than 2 hours per day
        [ ] 2 to 4 hours per day
        [ ] Over 4 hours per day
12. During the period you are using the respirator(s), is your work effort:
   a. Light (less than 200 kcal per hour): Yes □ No □
      If “yes,” how long does this period last during the average shift: _______ hrs. _______ mins.
      Examples of light work effort are sitting while writing, typing, drafting, or performing light assembly work;
      or standing while operating a drill press (1-3 lbs.) or controlling machines.
   b. Moderate (200 to 350 kcal per hour): Yes □ No □
      If “yes,” how long does this period last during the average shift: _______ hrs. _______ mins.
      Examples of 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 lbs.)
      at truck level; walking on a level surface about 2 mph or own a 5-degree grade about 3 mph; or pushing a
      wheelbarrow with a heavy load (about 100 lbs.) on a level surface.
   c. Heavy (above 350 kcal per hour): Yes □ No □
      If “yes,” how long does this period last during the average shift: _______ hrs. _______ mins.
      Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder;
      working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-
      degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you’re using
    the respirator? Yes □ No □
    If “yes,” describe this protective clothing and/or equipment:

14. Will you be working under hot conditions (temperature exceeding 770 F)? Yes □ No □

15. Will you be working under humid conditions? Yes □ No □

16. Describe the work you’ll be doing while you’re using the respirator(s):

17. Describe any special or hazardous conditions you might encounter when you’re using your respirator(s)
    (for example, confined spaces, life-threatening gases):

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):

   Name of the first toxic substance: ______________________
   Estimated maximum exposure level per shift: ______________________
   Duration of exposure per shift: ______________________

   Name of the second toxic substance: ______________________
   Estimated maximum exposure level per shift: ______________________
   Duration of exposure per shift: ______________________

   Name of the third toxic substance: ______________________
   Estimated maximum exposure level per shift: ______________________
   Duration of exposure per shift: ______________________

   Give the name of other toxic substances that you’ll be exposed to while using your respirator:

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 or security):


Respirator Users Approval Document

On ______/_______/____, I do hereby attest that upon reviewing the medical questionnaire and based on my best medical judgment, __________________ is (initial all that apply):

(name)

_____ Approved to wear the following respirators:

_____ Filtering Face Piece (N-95)

_____ Escape Only Respirator

_____ Half Mask Respirator

_____ Full Mask Respirator

_____ Required to come in for a medical evaluation before respirator clearance can be given.

_____ Approved with the following conditions: ________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

_____ Not approved for respirator use.

Signature of PLHCP _________________________ Date _________________________