Medical Evaluation and Questionnaire Requirements

The requirements of the medical evaluation and for using the questionnaire are provided below:

• The employer must identify a physician or other licensed health care professional (PLHCP) to perform all medical evaluations using the medical questionnaire in Appendix C of the Respiratory Protection standard or a medical examination that obtains the same information. (See Paragraph (e)(2)(i).)

• The medical evaluation must obtain the information requested in Sections 1 and 2, Part A of Appendix C. The questions in Part B of Appendix C may be added at the discretion of the health care professional. (See Paragraph (e)(2)(ii).)

• The employer must ensure that a follow-up medical examination is provided for any employee who gives a positive response to any question among questions 1 through 8 in Part A Section 2, of Appendix C, or whose initial medical examination demonstrates the need for a follow-up medical examination. The employer must provide the employee with an opportunity to discuss the questionnaire and examination results with the PLHCP. (See Paragraph (e)(3)(i).)

• The medical questionnaire and examinations must be administered confidentially during the employee’s normal working hours or at a time and place convenient to the employee and in a manner that ensures that he or she understands its content. The employer must not review the employee’s responses, and the questionnaire must be provided directly to the PLHCP. (See Paragraph (e)(4)(i).)

Excerpt from Appendix C of 29 CFR 1910.134: OSHA Respirator Medical Evaluation Questionnaire

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: 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.

Once filled out, this form must be given to the PLHCP. This form should not be submitted to OSHA.
Part A Section 1. (Mandatory) 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 age (to nearest year):
4. Sex (circle one): Male/Female
5. Your height: ______ ft. ______ in.
7. Your job title:
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the 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 (circle one): Yes/No
11. Check the type of respirator you will use (you can check more than one category):
   a. ___ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
   b. ___ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator (circle one): Yes/No 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 circle “yes” or “no”).

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you <em>currently</em> smoke tobacco, or have you smoked tobacco in the last month?</td>
<td>☐</td>
</tr>
<tr>
<td>2. Have you <em>ever had</em> any of the following conditions?</td>
<td>☐</td>
</tr>
<tr>
<td>a. Seizures</td>
<td>☐</td>
</tr>
<tr>
<td>b. Diabetes (sugar disease)</td>
<td>☐</td>
</tr>
<tr>
<td>c. Allergic reactions that interfere with your breathing</td>
<td>☐</td>
</tr>
<tr>
<td>d. Claustrophobia (fear of closed-in places)</td>
<td>☐</td>
</tr>
<tr>
<td>e. Trouble smelling odors</td>
<td>☐</td>
</tr>
<tr>
<td>3. Have you <em>ever had</em> any of the following pulmonary or lung problems?</td>
<td>☐</td>
</tr>
<tr>
<td>a. Asbestosis</td>
<td>☐</td>
</tr>
<tr>
<td>b. Asthma</td>
<td>☐</td>
</tr>
</tbody>
</table>
In the past two years, have you noticed your heart skipping or missing a beat any of the following cardiovascular or heart symptoms?

- Frequent pain or tightness in your chest
- Coughing up blood in the last month
- Shortness of breath that interferes with your job
- Swelling in your legs or feet (not caused by walking)
- Any other heart problem that you've been told about
- Take medication for any of the following problems:
  - Heart attack
  - Coughing that wakes you early in the morning
  - Breathing or lung problems
  - Heartburn or indigestion that is not related to eating
  - Heart arrhythmia (heart beating irregularly)
  - Stroke
  - High blood pressure
  - Coughing that occurs mostly when you are lying down
  - Heart trouble
  - Any other symptoms that you think may be related to lung problems
  - Wheezing that interferes with your job
  - Heart failure
  - Pain or tightness in your chest during physical activity
  - Wheezing
  - Any other symptoms that you think may be related to heart or circulation problems
  - Trouble smelling odors
  - Have to stop for breath when walking at your own pace on level ground
  - Seizures
  - Claustrophobia (fear of closed-in places)
  - Have to stop for breath when walking with other people at an ordinary pace on level ground or incline
  - Severe coughing
  - Shortness of breath when walking with other people at an ordinary pace on level ground
  - Ever had a heart attack
  - Ever had a stroke
  - Ever had a heart attack or stroke
  - Ever had any type of cardiovascular surgery or heart procedure
  - Any chest injuries or surgeries
  - Any other lung problem that you've been told about
  - Any other symptoms that you think may be related to lung problems
  - Any other symptoms that you think may be related to heart problems
  - Any other symptoms that you think may be related to cardiovascular problems
  - Any other symptoms that you think may be related to asthma or emphysema
  - Any other symptoms that you think may be related to allergic reactions
  - Any other symptoms that you think may be related to smoking
  - Any other symptoms that you think may be related to secondhand smoke

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

- Shortness of breath
- Shortness of breath when walking fast on level ground or walking up a slight hill or incline
- Shortness of breath when walking with other people at an ordinary pace on 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

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

- Heart attack
- Stroke
- Angina
- Heart failure
### Questions 1 to 8

#### 1. Have you ever had any of the following musculoskeletal problems?
- a. Weakness in any of your arms, hands, legs, or feet
- b. Worn a hearing aid
- c. Difficulty hearing
- d. Difficulty fully moving your arms and legs
- e. Skin allergies or rashes
- f. Eye irritation
- g. Allergic reactions that interfere with your breathing
- h. Pneumothorax (collapsed lung)
- i. Any chest injuries or surgeries
- j. Any other musculoskeletal problem

#### 2. Have you ever had any of the following respiratory problems?
- a. Shortness of breath when washing or dressing yourself
- b. Shortness of breath when walking fast on level ground or walking up a slight hill
- c. Shortness of breath when walking with other people at an ordinary pace on level ground
- d. Have to stop for breath when walking at your own pace on level ground
- e. Shortness of breath that interferes with your job
- f. Shortness of breath that occurs mostly when you are lying down
- g. Coughing that wakes you early in the morning
- h. Coughing that occurs mostly when you are lying down
- i. Coughing up blood in the last month
- j. Any other respiratory problem

#### 3. Have you ever had any of the following gastrointestinal problems?
- a. Swallowing problems
- b. Nausea
- c. Diarrhea
- d. Constipation
- e. Any other gastrointestinal problem

#### 4. Have you ever had any of the following cardiovascular or heart symptoms?
- a. Frequent pain or tightness in your chest
- b. Pain or tightness in your chest during physical activity
- c. Pain or tightness in your chest that interferes with your job
- d. In the past two years, have you noticed your heart skipping or missing a beat
- e. Heartburn or indigestion that is not related to eating
- f. Any other symptoms that you think may be related to heart or circulation problems

#### 5. Have you ever had any of the following vision problems?
- a. Weakness in any of your arms, hands, legs, or feet
- b. Worn a hearing aid
- c. Difficulty hearing
- d. Difficulty fully moving your arms and legs
- e. Skin allergies or rashes
- f. Eye irritation
- g. Allergic reactions that interfere with your breathing
- h. Pneumothorax (collapsed lung)
- i. Any chest injuries or surgeries
- j. Any other musculoskeletal problem
- k. Any other cardiovascular or heart problem
- l. Any other gastrointestinal problem
- m. Any other respiratory problem
- n. Any other vision problem

#### 6. Have you ever had any of the following symptoms of pulmonary or lung illness?
- a. Shortness of breath
- b. Difficulty hearing
- c. Difficulty fully moving your arms and legs
- d. Skin allergies or rashes
- e. Eye irritation
- f. Allergic reactions that interfere with your breathing
- g. Pneumothorax (collapsed lung)
- h. Any chest injuries or surgeries
- i. Any other musculoskeletal problem
- j. Any other gastrointestinal problem
- k. Any other cardiovascular or heart problem
- l. Any other respiratory problem
- m. Any other vision problem
- n. Any other problem that interferes with your use of a respirator

#### 7. Have you ever had any of the following problems?
- a. Weakness in any of your arms, hands, legs, or feet
- b. Worn a hearing aid
- c. Difficulty hearing
- d. Difficulty fully moving your arms and legs
- e. Skin allergies or rashes
- f. Eye irritation
- g. Allergic reactions that interfere with your breathing
- h. Pneumothorax (collapsed lung)
- i. Any chest injuries or surgeries
- j. Any other musculoskeletal problem
- k. Any other gastrointestinal problem
- l. Any other respiratory problem
- m. Any other vision problem
- n. Any other problem that interferes with your use of a respirator

#### 8. Do you currently take medication for any of the following problems?
- a. Breathing or lung problems
- b. Heart trouble
- c. Blood pressure
- d. Seizures

#### 9. Have you ever had any of the following conditions?
- a. Diabetes (sugar disease)
- b. Heart trouble
- c. High blood pressure
- d. High blood pressure
- e. High blood pressure
- f. Any other cardiovascular or heart problem
- g. Any other gastrointestinal problem
- h. Any other respiratory problem
- i. Any other vision problem
- j. Any other problem that interferes with your use of a respirator

#### 10. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

### Questions 9 to 15

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

#### 10. Have you ever lost vision in either eye (temporarily or permanently)?

#### 11. Do you currently have any of the following vision problems?
- a. Wear contact lenses
- b. Wear glasses
- c. Color blind
- d. Any other eye or vision problem

#### 12. Have you ever had any of the following eye problems?
- a. Weakness in any of your arms, hands, legs, or feet
- b. Worn a hearing aid
- c. Difficulty hearing
- d. Difficulty fully moving your arms and legs
- e. Skin allergies or rashes
- f. Eye irritation
- g. Allergic reactions that interfere with your breathing
- h. Pneumothorax (collapsed lung)
- i. Any chest injuries or surgeries
- j. Any other musculoskeletal problem
- k. Any other gastrointestinal problem
- l. Any other respiratory problem
- m. Any other vision problem
- n. Any other problem that interferes with your use of a respirator

#### 13. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

#### 14. Do you currently take medication for any of the following problems?
- a. Breathing or lung problems
- b. Heart trouble
- c. Blood pressure
- d. Seizures

#### 15. Have you ever had any of the following conditions?
- a. Diabetes (sugar disease)
- b. Heart trouble
- c. High blood pressure
- d. High blood pressure
- e. Any other cardiovascular or heart problem
- f. Any other gastrointestinal problem
- g. Any other respiratory problem
- h. Any other vision problem
- i. Any other problem that interferes with your use of a respirator
<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Have you ever had an injury to your ears, including a broken eardrum?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Do you currently have any of the following hearing problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Difficulty hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Wear a hearing aid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Any other hearing or ear problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Have you ever had a back injury?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Do you currently have any of the following musculoskeletal problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Weakness in any of your arms, hands, legs, or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Back pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Difficulty fully moving your arms and legs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Pain and stiffness when you lean forward or backward at the waist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Difficulty fully moving your head up or down</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Difficulty fully moving your head side to side</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Difficulty bending at your knees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Difficulty squatting to the ground</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Any other muscle or skeletal problem that interferes with using a respirator</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This infosheet does not include the questions in Part B because they are not mandatory; rather, they may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

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