Medical Evaluation Questionnaire  
(29 CFR 1910.134 App C)

To the Employer: Answers to questions in Section 1, and to question 9 in Section 2 do not require a medical examination.

To the employee: Can you read (circle one):

Yes     No

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.

Section 1. PERSONAL INFORMATION (MANDATORY)

Date: ________  Name: ________________________________
        (first)            (middle)               (last)

DOB: _____ Sex (circle one): Male     Female   Height: ____ ft. ____ in.  Weight: _____ lbs.

Job Title: ___________________________  Department: ___________________________

A phone number where you can be reached by the health care professional who reviews this questionnaire: ____________  The best time to phone you at this number: ____________

Has your employer told you how to contact the health care professional who will review this questionnaire? (circle one):

Yes     No

Check the type of respirator you will use (you can check more than one category)

a. ______ N, R, or P disposable respirator you will use (you can check more than one category)
b. ______ Other type (for example, half- or full-face piece type, powered-air purifying, supplies-air, self-contained breathing apparatus)

Have you worn a respirator in the last year? (circle one):

Yes     No

If "yes," what type(s): ____________________________
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" to the following.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month: Yes No

2. Have you ever had any of the following conditions?
   a. Seizures (fits): Yes No
   b. Diabetes (sugar disease): Yes No
   c. Allergic reactions that interfere with your breathing: Yes No
   d. Claustrophobia (fear of closed-in places): Yes No
   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've 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) not associated with a cold: 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 symptoms 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*

7. Do you **currently** take medication for any of the following problems?  
   a. Breathing or lung problems:  
      *Yes*  
      *No*
   b. Heart trouble:  
      *Yes*  
      *No*
   c. Blood pressure:  
      *Yes*  
      *No*
   d. Seizures (fits):  
      *Yes*  
      *No*
   e. Other ___________________________________________

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*

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 10-15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators (e.g.-N-95 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*
    e. 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 following hearing problems?  
    a. Difficulty hearing:  
       *Yes*  
       *No*
    b. Wear a hearing aid:  
       *Yes*  
       *No*
    c. Any other hearing or ear problem:  
       *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
   b. Back pain:  
      Yes  No
   c. Difficulty fully moving your arms and legs:  
      Yes  No
   d. Pain or stiffness when you lean forward or backward at the waist:  
      Yes  No
   e. Difficulties fully moving your head up or down:  
      Yes  No
   f. Difficulty fully 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

The following questions are at the discretion of the Licensed Health Care Provider:

16. Has your health changed within the past year? If “yes”, describe:  
   ________________________________________________  
   ________________________________________________  
   ________________________________________________  
Yes  No