MEDXCEL
OCCUPATIONAL MEDICINE & WALK-IN CLINIC
121 Tivoli Street; Abbeville, LA 70510
Phone: 337-893-0788 Fax: 337-893-0787

Name: _____ Date: _____

Social Security Number: _____

The above name individual has completed the medical evaluation required by OSHA in the respiratory standard 1910.134. The evaluation consisted of the following checked items:

- ☐ OSHA questionnaire (1910.134)
- ☐ Medical examination
- ☐ Pulmonary function testing
- ☐ Electrocardiogram
- ☐ Other: _____

Based on the above evaluation:

- ☐ I find this individual medically qualified to use a _____ Respirator _____ SCBA
- ☐ I find this individual qualified to use a respirator with the following limitation:
  _____ Escape purpose only _____ Weight limit on SCBA
  _____ Time Limit
- ☐ I recommend follow-up medical evaluations on a yearly basis.
- ☐ I **DO NOT** find this individual medically qualified to wear a respirator.
- ☐ Physical examination is required prior to respirator clearance.

_____

- ☐ David Silar, M.D.
- ☐ Chet Stelly, FNP-C
- ☐ Marissa Guidry, FNP-C

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RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Appendix C to sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

To the employer: Answers to questions in section 1, and to question 9 in section 2 of part A, do not required 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 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.

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:** _____
4. **Sex (circle one):** Male / Female

PLEASE ALLOW MEDIC TO WEIGH YOU BEFORE ANSWERING THE FOLLOWING TWO QUESTIONS

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. (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 (circle one):** Yes / No

Name:_____ Date:_____

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 face piece 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 check "yes" or "no").

YES	NO	
_____	_____	**1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?**
		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
		3. Have you ever had any of the following pulmonary or lung problems?
_____	_____	Asbestosis
_____	_____	Asthma
_____	_____	Chronic bronchitis
_____	_____	Emphysema
_____	_____	Tuberculosis
_____	_____	Silicosis
_____	_____	Pneumothorax (collapsed lung)
_____	_____	Lung cancer
_____	_____	Broken ribs
_____	_____	Any chest injuries or surgeries
_____	_____	Any other lung problems that you've been told about

Name:_____ Date:_____

YES	NO	
		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 up 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
_____	_____	Swelling in your legs or feet (not caused by walking)
_____	_____	Heart arrhythmia (irregular heart beat)
_____	_____	High blood pressure
_____	_____	Any other heart problems that you've been told about
		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 or circulation problems
		7. Do you currently take medication for any of the following problems?
_____	_____	Breathing or lung problems
_____	_____	Heart trouble
_____	_____	Blood pressure
_____	_____	Seizures (fits)

Name:_____ Date:_____

YES NO

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):

_____ _____ Eye irritation
_____ _____ Skin allergies or rash
_____ _____ Anxiety
_____ _____ General weakness or fatigue
_____ _____ Any other problems that interferes with your use of a respirator

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

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)**

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

_____ _____ Wear contact lenses
_____ _____ Wear glasses
_____ _____ Color blind
_____ _____ Any other eye or vision problems

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

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

_____ _____ Difficulty hearing
_____ _____ Wearing a hearing aid
_____ _____ Any other hearing or ear problems

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

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

_____ _____ Weakness in any of your arms, hands, legs, or feet
_____ _____ Back pain
_____ _____ Difficulty fully moving your arms or legs
_____ _____ Pain or stiffness when you lean forward or backward at the waist
_____ _____ Difficulty fully moving your head up or down or side to side
_____ _____ Difficulty bending at your knees
_____ _____ Difficulty squatting to the ground
_____ _____ Climbing a flight of stairs or a ladder carrying more than 25 lbs.
_____ _____ Any other muscle or skeletal problems that interferes with using a respirator

Name:_____ Date:_____

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.

YES NO

_____ _____ **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?**

_____ _____ **If yes, do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these condition?**

_____ _____ **2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g. gases, fumes, or dust), or have you come into skin contact with hazardous chemicals?**

If yes, name the chemicals if you know them: _____

3. Have you ever worked with any of the materials, or under any of these conditions?

_____ _____ Asbestos
_____ _____ Silica (e.g. in sandblasting)
_____ _____ Tungsten/Cobalt (e.g. grinding or welding this material)
_____ _____ Beryllium
_____ _____ Aluminum
_____ _____ Coal (for example, mining)
_____ _____ Iron
_____ _____ Tin
_____ _____ Dusty environments
_____ _____ Any other hazardous exposures

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: _____

_____

Name_____ Date:_____

YES	NO	
_____	_____	**7. Have you been in the military services?**
_____	_____	If yes, were you exposed to biological or chemical agents? (either in training or combat)
_____	_____	**8. Have you ever worked on a HAZMAT team?**
_____	_____	**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 medication)**

If yes, name the medications:_____

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

_____	_____	HEPA Filters
_____	_____	Canisters (for example, gas masks)
_____	_____	Cartridges

11. How often are you expected to use the respirators? (check all that apply to you)

_____	_____	Escape only (no rescue)
_____	_____	Emergency rescue only
_____	_____	Less than 5 hours per week
_____	_____	Less than 2 hours per week
_____	_____	2 to 4 hours per day
_____	_____	Over 4 hours per day

12. During the period you are using the respirator, is your work effort:

_____ _____ Light(less than 200 kcal per hour)

If yes, how long does this period last during the average shift: _____hrs. _____mins

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

_____ _____ Moderate (200-350 kcal per hour)

If yes, how long does this period last during the average shift: _____hrs. _____mins.

Examples of moderate work efforts are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assemble work, or transferring a moderate load (about 35 lbs.) at trunk 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 lbs.) on a level surface.

Name:_____ Date:_____

YES NO

_____ _____ Heavy (above 350 kcal per hour)

If yes, how long does this period last during the average shift: _____hrs. _____mins.

Explains 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 your respirator?**

If yes, describe this protective clothing and/or equipment: _____

_____

_____ _____ **14. Will you be working under hot conditions (temperature exceeding 77 deg. F)?**

_____ _____ **15. Will you be working under humid condition?**

16. Describe the work you'll be doing while using your respirator: _____

_____

17. Describe any special or hazardous conditions you might encounter when using your respirator. (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 using your respirator:

Name of first toxic substance: _____

Estimated max exposure level per shift: _____

Duration of exposure per shift: _____

Name of second toxic substance: _____

Estimated max exposure level per shift: _____

Duration of exposure per shift: _____

Name of third toxic substance: _____

Estimated max exposure level per shift: _____

Duration of exposure per shift: _____

19. Describe any special responsibilities you'll have while using your respirator that may affect the safety and well-being of others (for example, rescue, security): _____

_____

_____