



**OCCUPATIONAL MEDICINE & WALK-IN CLINIC**

106 Heritage Parkway; Broussard, LA 70518

Phone: 337-856-7500 Fax: 337-856-7502

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

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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.
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- 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): \_\_\_\_\_

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**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?**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath  |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath when walking fast on level ground or walking up a slight hill or incline |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath when walking with other people at an ordinary pace on level ground       |
| <input type="checkbox"/> | <input type="checkbox"/> | Have to stop for breath when walking at your own pace on level ground                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath when washing or dressing yourself  |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath that interferes with your job  |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing that produces phlegm (thick sputum)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing that wakes you up early in the morning  |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing that occurs mostly when you are lying down  |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing up blood in the last month  |
| <input type="checkbox"/> | <input type="checkbox"/> | Wheezing   |
| <input type="checkbox"/> | <input type="checkbox"/> | Wheezing that interferes with your job   |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain when you breathe deeply   |
| <input type="checkbox"/> | <input type="checkbox"/> | 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?**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack  |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke  |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina  |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart failure   |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling in your legs or feet (not caused by walking) |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart arrhythmia (irregular heart beat)               |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Any other heart problems that you've been told about  |

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

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent pain or tightness in your chest  |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain or tightness in your chest during physical activity                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain or tightness in your chest that interferes with your job                     |
| <input type="checkbox"/> | <input type="checkbox"/> | In the past two years, have you noticed your heart skipping or missing a beat     |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn or indigestion that is not related to eating                            |
| <input type="checkbox"/> | <input type="checkbox"/> | 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?**

- |                          |                          |                            |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Breathing or lung problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble              |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood pressure             |
| <input type="checkbox"/> | <input type="checkbox"/> | 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):** \_\_\_\_\_