



3235 Perkins Road  
Baton Rouge, LA 70808  
Office: (225) 387-3030  
Fax: (225) 387-4521

8742 Goodwood Blvd  
Baton Rouge, LA 70806  
Office: (225) 231-7070  
Fax: (225) 231-7069

13466 Vera McGowan Road  
Walker, LA  
Office: (225) 380-1720  
Fax: (225) 380-1719

<b>Original Date:</b>	
<b>Dates Revised:</b>	

Company: \_\_\_\_\_

Can you read (circle one): YES / NO

**OSHA Respirator Medical Evaluation Questionnaire**

CFR App. C to 1910.137, January 8, 1998

Before you answer this questionnaire ask your employer to give you information on: type or respirators you will use, for how long (hours/day, times/week), under what conditions (temp., humidity), and type of physical effort and other protective gear you will wear. Examples of physical effort are given under part B item 12, page 4 (a sample information form is given below).

**Information on your work conditions** (please mark as appropriate):

1. Type or respirator to be used	<input type="checkbox"/> Air Purifying	<input type="checkbox"/> Air Supplied	<input type="checkbox"/> Self-Contained	<input type="checkbox"/> Other
		Model & Series:		Weight:
2. Duration of work with respirators	Hours/day:	Days/week	Other:	
3. Expected physical work	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy	<input type="checkbox"/> Other
4. Other additional protective gear or PPE you will wear:				
5. Working Conditions	Temperature:	Humidity	Other:	

**\* Your employer must allow you to answer this questionnaire during normal working hours, or at a time or 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.\***

**\*DO NOT FORGET TO SIGN BELOW THE STATEMENT SAYING THAT YOU HAVE ANSWERED THESE QUESTIONS TRUTHFULLY AT THE END OF THIS QUESTIONNAIRE**

**\*ALL PARTS OF THIS QUESTIONNAIRE MUST BE ANSWERED. QUESTIONS 10-15 OF PART A SECTION 2 ARE TO BE ANSWERED ONLY BY EMPLOYEES WHO WILL USE a full-face piece respirator or a self-contained breathing apparatus (SCBA).**

<b>Part A. Section 1:</b> The following information must be provided by every employee who has been selected to use any type of respirator (please print and check YES / NO as necessary).	
<b>1. Today's Date:</b>	<b>2. Your Name:</b>
<b>3. Your Age:</b>	<b>4. Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F
<b>5. Your Height:</b>	<b>6. Your Weight:</b>
<b>7. Job Title:</b>	

Please write your name here: \_\_\_\_\_

<b>8. A phone number where you can be reached by the health care professional who reviews this questionnaire can reach you (include Area Code):</b>		
<b>9. Best time to call you at this number:</b>		
<b>10. Has your employer told you how to contact the person who will review this questionnaire?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>11. Check the type of respirator you will use (you can check more than one category):</b>		
<input type="checkbox"/> N.R. or P disposable respirator (filter-mask, non-cartridge type only).	<input type="checkbox"/> Other type (for example, half-or full face piece type, powered-air purifying, supplied air, self-contained breathing apparatus)	
<b>12. Have you worn a respirator?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If "yes", what types:		

**VERY IMPORTANT:** *If your answer is yes to any of the question concerning your health in this questionnaire, you must describe them in detail answering these questions: did you have the problem in the past or are you currently suffering from the problem? Is it under control now? Are you taking medications for it? Are you under a physician's supervision?*

<b>Part A. Section 2:</b> 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")		
<b>1. Do you currently smoke tobacco; or have you smoked tobacco in the last month?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>2. Have you ever had any of the following conditions?</b>		
a. Seizures (fits)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Diabetes (sugar disease)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Allergic reactions that interfere with your breathing	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. Claustrophobia(fear of closed-in places)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e. Trouble smelling odors	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If "YES" please explain in detail:		
<b>3. Have you ever had any of the following pulmonary or lung problems?</b>		
a. Asbestoses	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Emphysema	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. Pneumonia	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e. Silicosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
f. Lung Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> NO
g. Broken ribs	<input type="checkbox"/> YES	<input type="checkbox"/> NO
h. Tuberculosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
i. Pneumothorax (collapsed lung)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
j. Chronic bronchitis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
k. Any chest injuries or surgeries	<input type="checkbox"/> YES	<input type="checkbox"/> NO
l. Any other lung problems you had	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If "YES" please explain in detail:		
<b>4. Do you currently have any of the following symptoms of pulmonary or lung illness?</b>		
a. Shortness of breath	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Please write your name here: \_\_\_\_\_

e. Shortness of breath when washing or dressing yourself	<input type="checkbox"/> YES	<input type="checkbox"/> NO
f. Shortness of breath that interferes with your job	<input type="checkbox"/> YES	<input type="checkbox"/> NO
g. Coughing that produces phlegm (thick sputum)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
h. Coughing that wakes you early in the morning	<input type="checkbox"/> YES	<input type="checkbox"/> NO
i. Coughing that occurs mostly when you are lying down	<input type="checkbox"/> YES	<input type="checkbox"/> NO
j. Coughing up blood in the past month	<input type="checkbox"/> YES	<input type="checkbox"/> NO
k. Wheezing	<input type="checkbox"/> YES	<input type="checkbox"/> NO
l. Wheezing that interferes with your job	<input type="checkbox"/> YES	<input type="checkbox"/> NO
m. Chest pain when you breathe deeply	<input type="checkbox"/> YES	<input type="checkbox"/> NO
n. Any other symptoms that you think may be related to lung problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO

If "YES" please explain in detail:

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

a. Heart attack	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Angina	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. Heart failure	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e. Swelling in your legs or feet (not caused by walking)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
f. Heart arrhythmia (heart beating irregularly)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
g. High blood pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO
h. Any other heart problem that you've been told about	<input type="checkbox"/> YES	<input type="checkbox"/> NO

If "YES" please explain in detail:

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

a. Frequent pain or tightness in your chest	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Pain or tightness in your chest during physical activity	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Pain or tightness in your chest that interferes with your job	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. In the past two years, have you noticed your heart skipping or missing a beat	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e. Heartburn or indigestion that is not related to eating	<input type="checkbox"/> YES	<input type="checkbox"/> NO
f. Any other symptoms that you think may be related to heart or circulation problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO

If "YES" please explain in detail:

**7. Do you currently take medication for any of the following problems?**

a. Breathing or lung problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Heart trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Blood pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. Seizures (fits)	<input type="checkbox"/> YES	<input type="checkbox"/> NO

If "YES" please explain in detail and list the name of 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	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Skin allergies or rashes	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Any other problem that interferes with your use of a respirator:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. General weakness or fatigue	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e. Anxiety	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Please write your name here: \_\_\_\_\_

If "YES" please explain in detail:

**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). Those who have been selected to use other types of respirators, answering these questions are voluntary.

**10. Have you ever lost vision in either eye (temporarily or permanently)**  YES  NO

If "YES" please explain in detail:

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

- |                                     |                              |                             |
|-------------------------------------|------------------------------|-----------------------------|
| a. Wear contact lenses              |                              |                             |
| b. Wear glasses                     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| c. Color blindness                  |                              |                             |
| d. Any other eye or vision problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

If "YES" please explain in detail:

**12. Have you ever had an injury to your ears, including a broken ear drum?**  YES  NO

If "YES" please explain in detail:

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

- |                                      |                              |                             |
|--------------------------------------|------------------------------|-----------------------------|
| a. Difficulty hearing                | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| b. Wear a hearing aid                | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| c. Any other hearing or ear problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

If "YES" please explain in detail:

**14. Have you ever had a back injury?**  YES  NO

If "YES" please explain in detail:

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

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| a. Weakness in any of your arms, hands, legs or feet                            | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| b. Back pain  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| c. Difficulty fully moving your arms or legs                                    | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| d. Pain or stiffness when you lean forward or backward at the waist             | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| e. Difficulty fully moving your head up or down                                 | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| f. Difficulty fully moving your head side to side                               | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| g. Difficulty bending at your knees   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| h. Difficulty squatting to the ground   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.           | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| j. Any other muscle or skeletal problem that interferes with using a respirator | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

If "YES" please explain in detail:

**Part B.** Any of the following questions, and other questions not listed, maybe added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

**1. In you present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen?**  YES  NO

Please write your name here: \_\_\_\_\_

If "YES" do you have feeling of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If "YES" please explain in detail:		
<b>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?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If "YES" name the chemicals if you know them:		
<b>3. Have you ever worked with any of the materials, or under any of the conditions listed below:</b>		
a. Asbestos	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Silica (e.g., in sandblasting)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Tungsten/cobalt	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. Beryllium	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e. Aluminum	<input type="checkbox"/> YES	<input type="checkbox"/> NO
f. Coal	<input type="checkbox"/> YES	<input type="checkbox"/> NO
g. Iron	<input type="checkbox"/> YES	<input type="checkbox"/> NO
h. Tin	<input type="checkbox"/> YES	<input type="checkbox"/> NO
j. Any other hazardous exposure	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If "YES" to question describe these exposures. Did you have any problems with these exposures? Were you cleared for work after these exposures? Please explain:		
<b>4. List any second jobs or side businesses you have:</b>		
<b>5. List your previous occupations</b>		
<b>6. List your current and previous hobbies:</b>		
<b>7. Have you been in the military services?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If "YES", were you exposed to biological or chemical agents (either in training or combat)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If "YES", describe those exposures:		
<b>10. Will you be using any of the following items with your respirator(s)?</b>		
a. HEPA filters	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Canisters (e.g., gas masks)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Cartridges	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>11. How often are you expected to use the respirator(s):</b>		
a. Escape only (no rescue)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Emergency rescue only	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c. Less than 5 hrs. per week	<input type="checkbox"/> YES	<input type="checkbox"/> NO
d. Less than 2 hrs. per day	<input type="checkbox"/> YES	<input type="checkbox"/> NO
e. 2 to 4 hrs. per day	<input type="checkbox"/> YES	<input type="checkbox"/> NO
f. Over 4 hrs. per day	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>12. During the period you are using the respirator(s), is your work effort:</b>		
a. Light (less than 200 kcal per hour) <i>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.</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b. Moderate (200 to 350 kcal per hour)	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Please write your name here: \_\_\_\_\_

<i>Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic, standing while nailing, drilling, performing assembly work, or transferring a moderate load (about 35 lbs.) at true 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.</i>			
c. Heavy (about 350 kcal per hour) <i>Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or should; 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.)</i>		<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator?</b>		<input type="checkbox"/> YES	<input type="checkbox"/> NO
If "YES" describe this clothing and/or equipment:			
<b>14. Will you be working under hot conditions (temperature exceeding 77 degrees F)</b>		<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>15. Will you be working under humid conditions</b>		<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>16. Describe the work you'll will be doing while you're using your respirator(s):</b>			
<b>17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (e.g., confined spaces, life threatening gases:</b>			
<b>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):</b>			
Name of first toxic substance:			
Estimated maximum exposure level per shift:			
Duration of exposure per shift:			
Name of second toxic substance:			
Estimated maximum exposure level per shift:			
Duration of exposure per shift:			
Name of third toxic substance:			
Estimated maximum exposure level per shift:			
Duration of exposure per shift:			
Name any other toxic substances that you'll be exposed to while using your respirator:			
<b>19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (e.g., rescue, security)</b>			

**NOW PLEASE GO BACK TO EACH PAGE AND SEE IF YOU HAVE ANSWERED ALL THE QUESTIONS**

**Employee Acknowledgment** (YOU MUST READ and SIGN THIS STATEMENT)

I understand that not answering the above questions truthfully can threaten the safety of myself and others. Therefore, I hereby certify that to the best of my knowledge the answers I gave to the above questions on pages 1-4 are correct and I understand that any false statement or incorrect information may result in my termination and may forfeit my right to worker's compensation benefits under R.S. 23:1207.1

**Employee Name:** \_\_\_\_\_ **S.S. #:** \_\_\_\_\_

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Evaluation/Notes by health care professional who will review this questionnaire:**

Please write your name here: \_\_\_\_\_

- No medical conditions were found/detected which can prevent the employee from using respiratory protection as described
- Medical conditions were found which can prevent the employee from routine use of respiratory protection
- Medical conditions allow only for escape route or emergency use of respirators
- Medical evaluation is necessary before routine use of respiratory protection

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**If Respirator fit test is done, please fill out the following part:**

<b><u>Type of Mask fitted &amp; Manufacturer</u></b>	<b><u>Size</u></b>	<b><u>Fit Factor</u></b>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

**Other Tests**

\_\_\_\_\_  
**Technician Signature**

\_\_\_\_\_  
**Date**