OSHA Regulations (Standards - 29 CFR)
OSHA Respirator Medical Evaluation Questionnaire
(Mandatory). – 1910.134 App C

Please return to:
GMG EnviroSafe
1621 Kildeer Drive
Round Lake Beach, IL 60073
Fax: 847-740-1635

Medical Determination for Respirator Use

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

Company ______________ Location ______________ Date ______________

First ______________ Middle ______________ Last ______________

Contact Phone Number ______________ Best Time To Call □ Morning □ Afternoon □ Evening

□ Male □ Female Height: ft. in. Weight: lbs. Age ______________

Job Responsibilities (check all that apply):
□ Body Tech □ Painter □ Detail □ Mechanic □ Other: ______________
Type of Respirator Used (check all that apply):
□ Dust Mask □ Air Purifying Cartridge (Full or ½ Face) □ Powered Air Purifying □ Supplied air (airline)
Duration and Frequency Respirator Required to be Worn:
□ Rarely/Emergency Only □ Occasionally (2-4x per week) □ Daily How many hours per day? ______________
Expected physical work effort while wearing a respirator:
□ Light (Desk Job) □ Moderate (Assembly Line Duty) □ Heavy (Construction) □ Strenuous (Fire Fighting)
What are the following extremes that you are exposed to while working?
Temperature ______________ Humidity ______________
Have you ever worn a respirator before? If yes, what types?
□ Yes □ No Types: ______________
Has your employer told you how to contact the health care professional who will review this questionnaire?
□ Yes □ No

If you want to talk with the LHCP that reviews this form, please call 800-619-9733

Employee Signature ______________________________

Following to be Completed by Licensed Health Care Professional

□ No restriction on use of type of respirator identified above □ No respirator use permitted

□ Needs to be checked by local health professional □ Medical hold, awaiting more data

□ Restricted use stated as follows:
____
____
____

LHCP Name ______________ Phone Number ______________

LHCP Signature ______________ Date ______________

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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 circle "yes" or "no").

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):	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

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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
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