

29 CFR 1910.134 / CAL OSHA Title 8, 5144
Respiratory Protection Medical Form



To the employer: Answers to Questions in Section 1, and to question 9 in Section 2 Part A, 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 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. Company Name: _____
2. Today's date: _____
3. Your Name: _____
4. I.D. # (last 4 digits of your SS#) _____
5. Your Age (to the nearest year): _____
6. Sex (circle one): Male / Female
7. Your Height: _____ ft. _____ in.
8. Your Weight: _____ lbs.
9. Your job title: _____
Describe your job: _____
10. A phone number where you can be reached by ALLIANCE who will review this questionnaire, (_____) _____
11. The best time to phone you at that number: _____
12. Has your employer told you how to contact the health care professional who will review this questionnaire: Yes / No
13. Circle the type of respirator(s) you will be using:
(You can check more than one category)
 - a. _____ Filtering face-mask (dust mask)
 - b. _____ Other type (for example, half - mask, full- face mask, powered – air purifying, supplied air, self- contained breathing apparatus)
14. Have you ever worn a respirator (circle one): Yes / No
If Yes, what type(s): _____

Part A. Section 2. (Mandatory)

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 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 you job	YES / NO
d. In the past two years, have you noticed your heart skipping or missing a beat	YES / NO
e. Heart burn 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, skip question 8 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?	
Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or 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)?	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
d. Any other eye or vision problem	YES / NO
12. Have you ever had an injury to your ears, including a broken ear drum?	
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. Difficulty 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
Part B.	
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?	YES / NO
If “yes,” do you have feelings of dizziness, shortness of breath, pounding in your chest or other symptoms when you’re working under these conditions?	YES / NO
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?	YES / NO
If “yes,” name the chemicals, if you know them: _____ _____	
3. Have you ever worked with any of the materials, or under any of the conditions, listed below?	
a. Asbestos	YES / NO
b. Silica (e.g., in sandblasting)	YES / NO
c. Tungsten/cobalt (e.g., grinding or welding this material)	YES / NO
d. Beryllium	YES / NO

e. Aluminum	YES / NO
f. Coal	YES / NO
g. Iron	YES / NO
h. Tin	YES / NO
i. Dusty environments	YES / NO
j. Any other hazardous exposures	YES / NO
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: _____ _____ _____	
7. Have you been in the military services?	YES / NO
If “yes,” were you exposed to biological or chemical agents (either in training or combat)	YES / NO
8. Have you ever worked on a HAZMAT team?	YES / NO
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)	YES / NO

If “yes,” name the medications if you know them: _____ _____ _____	
10. Will you be using any of the following items with your respirator(s)?	
a. HEPA Filters	YES / NO
b. Canisters (for example, gas masks)	YES / NO
c. Cartridges	YES / NO
11. How often are you expected to use the respirator(s) (circle “yes” or “no” for all answers that apply to you)?	
a. Escape only (no rescue)	YES / NO
b. Emergency rescue only	YES / NO
c. Less than 5 hours per week	YES / NO
d. Less than 2 hours per day	YES / NO
e. 2 to 4 hours per day	YES / NO
f. Over 4 hours per day	YES / NO
12. During the period you are using the respirator(s), is your work effort:	
a. 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 effect are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.	YES / NO

b. Moderate (200 to 350 kcal per hour) If “yes,” how long does this period last during the average shift: _____ hrs. _____ mins. Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly 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.	YES / NO
c. Heavy (above 350 kcal per hour) If “yes,” how long does this period last during the average shift: _____ hrs. _____ mins. Examples 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 a 8-degree grade about 2-mph; climbing stairs with a heavy load (about 50 lbs.).	YES / NO
13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you’re using your respirator?	YES / NO
If “yes,” describe this protective clothing and/or equipment: _____ _____	
14. Will you be working under hot conditions? (temperature exceeding 77 deg. F)	YES / NO
15. Will you be working under humid conditions?	YES / NO
16. Describe the work you’ll be doing while you’re using your respirator(s): _____ _____ _____	

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

Name of the first toxic substance: _____

Estimated maximum exposure level per shift: _____

Name of the second toxic substance: _____

Estimated maximum exposure level per shift: _____

Name of the third toxic substance: _____

Estimated maximum exposure level per shift: _____

The name of any other toxic substances that you'll be exposed to while using your respirator

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

I acknowledge that the above stated information is accurate and true to the best of my knowledge:

(Employee Signature)

(Date)

(Clinician's Signature)

(Date)