Axiom Medical Consulting, LLC
Appendix C to Sec. 1910.134
OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

To the employee:
Can you read (check one): ☐ Yes ☐ No

You may complete this form on the computer through a word processor (i.e., Microsoft Word), then save it and e-mail it back to us, or you may print it and fax it back when completed.

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, only a representative of Axiom Medical Consulting, LLC and your company's Medical/Health Services representative can look at or review your answers. Please forward the completed questionnaire by mail, fax or e-mail to:

Axiom Medical Consulting, LLC
4840 W. Panther Creek Dr., Suite 106
The Woodlands, TX 77381
O: (281) 419-7063 F: (281) 465-7150

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 date of birth: ________
4. Sex (check one): ☐ Male ☐ Female
5. Your height: _____ ft. _____ in.
6. Your weight: _____ lbs.
7. Your job title: ______________________________
8. Your SSN or Employee I.D. # : ______________________________
9. A phone number where you can be (include the Area Code): ________________________________
10. The best time to phone you at this number: _______________________
11. Has your employer told you how to contact the health care professional who will review this questionnaire (check one): ☐ Yes ☐ No Company/Employer Name: ____________________
12. Check the type of respirator you will use (you can check more than one category):

_____ N R or P Disposable _____ Half Faced _____ Full Faced _____ Atmospheric Supplying (SCBA or Airline) ESCAPE ONLY

13. Have you worn a respirator (check one): ☐ Yes ☐ No

If "yes," what type(s):

_____ N R or P Disposable _____ Half Faced _____ Full Faced _____ Atmospheric Supplying (SCBA or Airline) ESCAPE ONLY

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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").

1. **Do you currently smoke tobacco, or have you smoked tobacco in the last month:** ☐ Yes ☐ No
   If yes, how much do you smoke daily and for how many years? _____ pks/day _____ years

2. **Have you ever had any of the following conditions?**
   a. Seizures (fits): ☐ Yes ☐ No
   If YES
      i. Was the most recent seizure with in the past two years?
      ____
      ii. Are you currently taking any prescription medication for seizures?
      ____
      iii. Are you currently under a doctor's care for seizures?
      ____
   b. Diabetes (sugar disease): ☐ Yes ☐ No
      i. Do you have Diabetes currently? ☐ Yes ☐ No
   If YES,
      i. How often do you check your sugar levels?
      _____Daily ______ Weekly _______ Less Frequently
      ii. Have you ever had any episodes of hypoglycemia (low sugar) in the past six months?
      ____
      iii. Do you take insulin?
      ____
      iv. Do you take oral medication (pills) for diabetes?
      ____
      v. Do you and your doctor think that your blood sugar is under control?
      ____
   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

If you answered No to ALL the questions listed above go to question 3.
If you answered Yes to ANY of the questions listed above explain how long; any medications:

____

Does any condition you answered Yes to above prevent you from wearing a respirator? ☐ 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

If you answered No to ALL the questions listed above go to question 4.
If you answered Yes to ANY of the questions listed above explain how long; any medications:

____

Does any condition you answered Yes to above prevent you from wearing a respirator? ☐ Yes ☐ No

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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 slight hill or incline: ☐ Yes ☐ No
c. Shortness of breath when walking with other people at an ordinary pace on level ground: ☐ Yes ☐ No
   i. Shortness of breath when wearing a respirator: ____________________
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

If you answered No to ALL the questions listed above go to question 5.
If you answered Yes to ANY of the questions listed above explain how long; any medications:

____

Does any condition you answered Yes to above prevent you from wearing a respirator? ☐ 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
   i. Have you ever been diagnosed with Congestive Heart Failure (CHF): ____________________
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

If you answered No to ALL the questions listed above go to question 6.
If you answered Yes to ANY of the questions listed above explain how long; any medications:

____

Does any condition you answered Yes to above prevent you from wearing a respirator? ☐ 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

If you answered No to ALL the questions listed above go to question 7.
If you answered Yes to ANY of the questions listed above explain how long; any medications:

____

Does any condition you answered Yes to above prevent you from wearing a respirator? ☐ 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
   i. If Yes, what was your last Blood Pressure reading? ____________________
d. Seizures (fits): ☐ Yes ☐ No

If you answered No to ALL the questions listed above go to question 8.
If you answered Yes to ANY of the questions listed above explain how long; any medications:

____

Does any condition you answered Yes to above prevent you from wearing a respirator? ☐ Yes ☐ No

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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

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full facepiece 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): ☐ 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 or pain: ☐ Yes ☐ No
    i. Do you feel your back pain will interfere with wearing a respirator?

    ____

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

Does any condition you answered Yes to above prevent you from wearing a SCBA? ☐ Yes ☐ No

16. In your present job, will you ever need to wear your respirator when working at high altitudes (over 8,000 Feet) or in a place that has lower than normal amounts of oxygen? ☐ Yes ☐ No
    i. If YES, do you have feelings of dizziness, shortness of breath, pounding in your chest or other symptoms when you are working under these conditions?

    ____

If you answered Yes to ANY of the questions (10 – 16) listed above explain how long; any medications:

____

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