MEDIC
Medical Excellence. Compassionate Care.

Medical Clearence Questionnaire (Mandatory)
Appendix C to 1910.134:0SHA

To the employee: Can you read: Yes No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient for 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)
Every employee who has been selected to use any type of respirator, must provide the following information (please print).

1. Today's date: _____

2. Your name: _____

3. Your age (to nearest year): _____ 4. Sex: Male Female 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 the 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? Yes No
11. Check the type of respirator you will use (you can check more than one category):
a. _____ N 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: Yes No If yes, what type(s): _____

Part A. Section 2. (Mandatory)
Every employee selected to use any type of respirator must answer questions 1 through 9 below.

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. 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. Asbestos: 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: 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
1. 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
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 2 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 problems 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: 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

_____ _____
Signature Date