OSHA Fit Testing Questionnaire

Appendix C to Section 1910.134 (29 CFR)
Pennsylvania State Police Fire Marshal Unit

To the Employer:

Answers to questions in Section 1, and to Section 2, question 9 of Part A, do not require a medical examination.

To the Employee:

Can you read? (check ✓ 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):

Today's Date: _____

Your Name: _____ Age (to nearest year): _____

Sex: ☐ Male ☐ Female Height: _____ft. _____in. Weight: _____

Job Title: _____

Phone number where you can be reached by the health care professional who reviews this questionnaire (include the area code): _____ Best time to contact you at this number: _____

Has your employer told you how to contact the health care professional who will review this questionnaire?

(check one) ☐**Yes** ☐**No**

Check the type of respirator you will use (you can check more than one category):

- ☐ N, R, or P disposable respiratory (filter-mask, non-cartridge type only).
- ☐ Other type (for example, half-or fill-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Have you ever worn a respirator (check one): ☐**Yes** ☐**No**

If yes, what type(s):_____

_____

Employee Signature: _____Date: _____

Reviewed by: _____Date: _____

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**

2. **Have you *ever had* any of the following conditions?**

Yes	No	Yes	No
☐	☐-Seizures (fits)	☐	☐-Diabetes (sugar disease)
☐	☐-Trouble smelling odors	☐	☐-Claustrophobia (fear of closed-in places)
☐	☐-Allergic reactions that interfere with your breathing		

3. **Have you *ever had* any of the following pulmonary or lung problems?**

Yes	No	Yes	No
☐	☐-Asbestosis	☐	☐-Asthma
☐	☐-Chronic bronchitis	☐	☐-Emphysema
☐	☐-Pneumonia	☐	☐-Tuberculosis
☐	☐-Silicosis	☐	☐-Pneumothorax (collapsed lung)
☐	☐-Lung cancer	☐	☐-Broken ribs
☐	☐-Any chest injuries or surgeries	☐	☐-Any other lung problem that you've been told about

4. **Do you *currently* have any of the following symptoms of pulmonary or lung illness?**

Yes	No
☐	☐-Shortness of breath
☐	☐-Shortness of breath when walking fast on level ground or walking up a slight hill or incline
☐	☐-Shortness of breath when walking with other people at an ordinary pace on level ground
☐	☐-Have to stop for breath when walking at your own pace on level ground
☐	☐-Shortness of breath when washing or dressing yourself
☐	☐-Shortness of breath that interferes with your job
☐	☐-Coughing that produces phlegm (thick sputum)
☐	☐-Coughing that wakes you early in the morning
☐	☐-Coughing that occurs mostly when you are lying down
☐	☐-Coughing up blood in the last month
☐	☐-Wheezing
☐	☐-Wheezing that interferes with your job
☐	☐-Chest pain when you breathe deeply
☐	☐-Any other symptoms that you think may be related to lung problems

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

Yes	No		Yes	No	
☐	☐	-Heart attack	☐	☐	-Stroke
☐	☐	-Angina	☐	☐	-Heart failure
☐	☐	-High blood pressure	☐	☐	-Heart arrhythmia (heart beating irregularly)
☐	☐	-Swelling in your legs or feet (not caused by walking)			
☐	☐	-Any other heart problem that you've been told about			

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

Yes	No	
☐	☐	-Frequent pain or tightness in your chest
☐	☐	-Pain or tightness in your chest during physical activity
☐	☐	-Pain or tightness in your chest that interferes with your job
☐	☐	-In the past two years, have you noticed your heart skipping or missing a beat
☐	☐	-Heartburn or indigestion that is not related to eating
☐	☐	-Any other symptoms that you think may be related to heart or circulation problems

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

Yes	No	
☐	☐	-Breathing or lung problems
☐	☐	-Heart trouble
☐	☐	-Blood pressure
☐	☐	-Seizures (fits)

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 box and proceed to question 9:

☐ **Never used a respirator**

Yes	No	
☐	☐	-Eye irritation
☐	☐	-Skin allergies or rashes
☐	☐	-Anxiety
☐	☐	-General weakness or fatigue
☐	☐	-Any other problem that interferes with your use of a respirator

9. **Would you like to talk to the health care professional who will review your answers to this questionnaire:** ☐Yes ☐No