OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

_____ _____/_____/_____ _____

Your Name: Last, First (Print) ***Date of Birth*** ***A #***

Sex (circle one): Male/Female Email Address: _____

Phone: (_____)_____-_____ Height: _____ feet _____ inches Weight: _____ lbs

Have you worn a respirator before (If "yes," what type): ☐Yes ☐No

_____

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

a. _____ N95

b. _____ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

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?
   - Seizures (fits): ---------- ☐Yes ☐No
   - Diabetes (sugar disease): ---------- ☐Yes ☐No
   - Allergic reactions that interfere with your breathing: ---------- ☐Yes ☐No
   - Claustrophobia (fear of closed-in places): ---------- ☐Yes ☐No
   - Trouble smelling odors: ---------- ☐Yes ☐No
3. Have you ever had any of the following pulmonary or lung problems?
   - Asbestosis: ---------- ☐Yes ☐No
   - Asthma: ---------- ☐Yes ☐No
   - Chronic bronchitis: ---------- ☐Yes ☐No
   - Emphysema: ---------- ☐Yes ☐No
   - Pneumonia: ---------- ☐Yes ☐No
   - Tuberculosis: ---------- ☐Yes ☐No
   - Silicosis: ---------- ☐Yes ☐No
   - Pneumothorax (collapsed lung): ---------- ☐Yes ☐No
   - Lung cancer: ---------- ☐Yes ☐No
   - Broken ribs: ---------- ☐Yes ☐No
   - Any chest injuries or surgeries: ---------- ☐Yes ☐No
   - 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?
   - Shortness of breath: ---------- ☐Yes ☐No
   - Shortness of breath walking fast on level ground/walking up a slight hill/incline: --- ☐Yes ☐No
   - Shortness of breath walking with other people at an ordinary pace on level ground: ☐Yes ☐No
   - Have to stop for breath when walking at your own pace on level ground: -- ☐Yes ☐No
   - Shortness of breath when washing or dressing yourself: ---------- ☐Yes ☐No
   - Shortness of breath that interferes with your job: ---------- ☐Yes ☐No
   - Coughing that produces phlegm (thick sputum): ---------- ☐Yes ☐No
   - Coughing that wakes you early in the morning: ---------- ☐Yes ☐No
   - Coughing that occurs mostly when you are lying down: ---------- ☐Yes ☐No
   - Coughing up blood in the last month: ---------- ☐Yes ☐No
   - Wheezing: ---------- ☐Yes ☐No
   - Wheezing that interferes with your job: ---------- ☐Yes ☐No
   - Chest pain when you breathe deeply: ---------- ☐Yes ☐No
   - 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?

Heart attack: ----------	☐Yes	☐No
Stroke: ----------	☐Yes	☐No
Angina: ----------	☐Yes	☐No
Heart failure: ----------	☐Yes	☐No
Swelling in your legs or feet (not caused by walking): ----------	☐Yes	☐No
Heart arrhythmia (heart beating irregularly): ----------	☐Yes	☐No
High blood pressure: ----------	☐Yes	☐No
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?

Frequent pain or tightness in your chest: ----------	☐Yes	☐No
Pain or tightness in your chest during physical activity: ----------	☐Yes	☐No
Pain or tightness in your chest that interferes with your job: ----------	☐Yes	☐No
In the past 2 years, have you noticed your heart skipping or missing a beat:	☐Yes	☐No
Heartburn or indigestion that is not related to eating: ----------	☐Yes	☐No
Any other symptoms that may be related to heart or circulation problems:	☐Yes	☐No

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

Breathing or lung problems: ----------	☐Yes	☐No
Heart trouble: ----------	☐Yes	☐No
Blood pressure: ----------	☐Yes	☐No
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) ---------- ☐N/A

Eye irritation: ----------	☐Yes	☐No
Skin allergies or rashes: ----------	☐Yes	☐No
Anxiety: ----------	☐Yes	☐No
General weakness or fatigue: ----------	☐Yes	☐No
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

"I verify that the information entered on this form is true, correct and complete to the best of my knowledge."

_____ _____ _____

Signature Printed Name Date

_____

Evaluator's Signature Evaluator's Printed Name Date