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

Revised 02/01/2021 by BJA