OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

Part A. Section 1. (Mandatory) Every employee who has been selected to use any type of respirator must provide the following information.

Print Name: _____Date:_____

Department: _____

To the Employer: Answers to questions in Part A. Section 1 and question 9 in Part A. Section 2, **do not require a medical examination.**

To the Employee: Can you read English? 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, to maintain your confidentiality, your employer or supervisor must not look at or review your answers. You may return the completed questionnaire to the Administration Office.

(Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator. (Please print clearly)

Today's Date: _____
Name: _____
Age: _____
Gender: Male ____ Female ____ Other ____
Height: _____ft. _____in.
Weight: _____lbs.
Job Title: _____
Phone number where you can be reached by the healthcare professional who reviews this questionnaire. (Include area code) _____
The best time to phone you at this number: _____
Has your employer told you how to contact the healthcare professional who will review this questionnaire?
Yes ____ No ____
Check the type of respirator you will use.
____ N95 Disposable Respirator (filter-mask, non-cartridge type only)
____Powered Air Purifying Respirator (PAPR)
Have you worn a respirator? Yes ____ No ____
If yes, what type? _____

Part A. Section 2. (Mandatory) Questions 1 through 9 must be answered by every employee who has been selected to use any type of respirator.

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: Yes ____ No ____
   b) Diabetes: Yes ____ No ____
   c) Allergic reactions that interfere with your breathing: Yes ____ No ____

d) Claustrophobia: Yes ____ No ____
e) Trouble smelling odors: Yes ____ No ____

3. Have you **ever had** any of the following pulmonary or lung problems?
a) Shortness of breath: 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 have 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) Must stop for a 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 mucus): Yes ____ No ____
h) Coughing that wakes you early in the morning: Yes ____ No ____
i) Coughing that wakes you early in the morning: 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 symptom that 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 have 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 ____

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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 ____

7. Do you currently take medication for any of the following problems?
a) Breathing or lung: Yes ____ No ____
b) Heart trouble: Yes ____ No ____
c) Blood pressure: Yes ____ No ____
d) Seizures: Yes ____ No ____

8. If you have used a respirator, have you ever had any of the following problems?
(if you have never used a respirator, check the following space _____ and go to the next question)
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 with the healthcare professional who will review this questionnaire: Yes ____ No ____

The N95 respirator is to be used when entering the room of a patient on Airborne precautions. The 95 respirator fits tightly and restricts air intake, and therefore requires medical clearance for both fit testing and use. Males must be clean shaven when they are fit, and any beard growth will affect the fit of the respirator. If you lose or gain 20 pounds or more, or have dental/facial trauma or surgery, you should have the fit of your respirator re-evaluated.

Please answer the following questions and sign acknowledgement

Do you have a history of high blood pressure, cerebral or coronary vessel disease, congestive heart disease, or COPD: Yes ____ No ____
Do you have chronic bronchitis or asthma: Yes ____ No ____
If you have asthma, have you ever had breathing problems when wearing a mask or respirator: Yes ____ No ____
Do you have any medical problems that might interfere with the use of a mask or respirator: Yes ____ No ____

Employee Signature: _____ Date: _____

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TO BE FILLED OUT BY THE EXAMINER/REVIEWER

This employee has been found to be physically able to us the following:

____ N 95 Disposable Respirator (filter-mask, non-cartridge type only)
____ Power Air Purifying respirator (PAPR)

Restrictions/ Limitations (if any) when wearing a respirator:
_____
_____
_____

____ This employee has been found to be physically **NOT able** to use a respirator.

____ The mandatory questionnaire has been reviewed but there is insufficient information to make a determination at this time.

____ Preliminary approval for use of a respirator (explanation)
_____
_____
_____

____ The mandatory questionnaire has been reviewed, and the employee has been found to be physically able to use a respirator.

This respirator clearance expires 1 _____ 2 _____ 3 _____ years from the date below
(**If not marked, clearance expires in 1 year)**

_____	_____	_____
Reviewer's Name (Print)	**Reviewer's Signature**	**Date**

_____

Fit Test Date: _____

Pass: _____

Fail: _____

Model: _____

Size: _____

Fit Tester's Signature: _____