Respirator Medical Evaluation Questionnaire - N95 (Respiratory Isolation Mask)

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

To the employee: Can you read? (circle 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).*

Name: _____ Date: _____

Phone # *(where you can be reached by the health care professional who reviews this questionnaire)*:(_____)_____

Job Title Medical Student (MD/MSPA)

DOB: _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____lbs.

1. Has your employer told you how to contact the health care professional who will review this questionnaire? (circle one) Yes/ No

2. Have you worn a respirator in the past? (circle one) Yes/ No

   If ``yes,'' what type(s) _____

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 indicate ``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?
   - a) Seizures (fits) ☐ Yes ☐ No
   - b) Diabetes (sugar disease) ☐ Yes ☐ No
   - c) Allergic 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) Asbestosis ☐ 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'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
l) 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 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 problems ☐ Yes ☐ No
b) Heart trouble ☐ Yes ☐ No
c) Blood pressure ☐ Yes ☐ No
d) Seizures (fits) ☐ Yes ☐ No

If "yes," name the medications if you know them:_____

_____

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

IF YOU ARE REQUIRED TO USE A FULL-FACE PIECE RESPIRRATOR OR A SELF-CONTAINED BREATHING APPARATUS (SCBA), COMPLETE SECTION B.

The Preceding information is true to the best of my knowledge

_____ _____
Employee's Signature **Date**

Medical Clearance
Medical Clearance for use of an N95 respirator in a clinical care setting:

_____ Approved

_____ Approved with Restrictions: _____

_____ Denied

_____ _____
Provider signature Date

Name: _____ Date: _____

Section B (QUESTIONS FOR FULL-FACEPIECE RESPIRATOR OR SCBA USERS)

1. **Have you ever lost vision in either eye (temporarily or permanently)** ..... Yes No

2. **Do you currently have any of the following vision problems?**
   a. Wear contact lenses ..... Yes No
   b. Wear glasses ..... Yes No
   c. Color blind ..... Yes No
   d. Any other eye or vision problem ..... Yes No

3. **Have you ever had an injury to your ears, including a broken ear drum** ..... Yes No

4. **Do you currently have any of the following hearing problems?**
   a. Difficulty hearing ..... Yes No
   b. Wear a hearing aid ..... Yes No
   c. Any other hearing or ear problem ..... Yes No

5. **Have you ever had a back injury** ..... Yes No

6. **Do you currently have any of the following musculoskeletal problems?**
   a. Weakness in any of your arms, hands, legs, or feet ..... Yes No
   b. Back pain ..... Yes No
   c. Difficulty fully moving your arms and legs ..... Yes No
   d. Pain or stiffness when you lean forward or backward at the waist ..... Yes No
   e. Difficulty fully moving your head up or down ..... Yes No
   f. Difficulty fully moving your head side to side ..... Yes No
   g. Difficulty bending at your knees ..... Yes No
   h. Difficulty squatting to the ground ..... Yes No
   i. Climbing a flight of stairs or a ladder carrying more than 25 lbs ..... Yes No
   j. Any other muscle or skeletal problem that interferes with using a respirator ..... Yes No

The Preceding information is true to the best of my knowledge

_____ _____
Employee's Signature **Date**

Medical Clearance

Medical Clearance for use of Full-Facepiece Respirator in a clinical care setting:

_____ Approved

_____ Approved with Restrictions: _____

_____ Denied

_____ _____
Provider signature Date