



## N95 RESPIRATOR ANNUAL MEDICAL EVALUATION

This questionnaire is used in determining whether you have any medical condition that may affect your ability to wear a respirator. Most employees will be approved to wear respirators based on the information obtained from this questionnaire. In some cases, more information may be requested. Fit testing of the respirator is also required and will be done separately. All medical information is considered confidential. This information will be included in your employee health file. Access to your employee health file will be in accordance with the OSHA standard, 1910.1020 (*Access to Employee Exposure and Medical Records*) and HIPPA.

Name:	Employee ID Number:	Today's Date:
Name of Manager:	Home Department	Position Title:
Work Phone:	Gender: <input type="checkbox"/> Male	DOB:
Home Phone:	<input type="checkbox"/> Female	
Have you ever worn a respirator before? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**All questions are mandatory per OSHA standard, 1910.134 and must be answered by every employee who has been selected to use any type of respirator. Please check "yes" or "no" to each question.**

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 (except when you had a cold) .....  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 problems 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

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- g. Coughing that produces phlegm (thick sputum): .....  Yes  No
- h. Coughing that wakes you early in the morning: .....  Yes  No
- i. Coughing that occurs 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 breath deeply: .....  Yes  No
- n. Any other symptom 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 problems?
- 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
8. Has your wearing a respirator caused any of the following problems?  
(If you have 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 that occurs only when you use the respirator: .....  Yes  No
- d. Unusual weakness or fatigue: .....  Yes  No
- e. Any other problem that interfaces 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

**Note:** If you experience any discomfort, or shortness of breath when wearing a respirator, immediately leave the high-risk area and then remove your respirator. If symptoms persist for more than 15 minutes, please report to Employee Health Services or contact the Administrative Nursing Supervisor (ANS) if after hours, weekends, or holidays. Do not continue to wear the respirator until you have been indicated to do so by the Employee Health Nurse or Emergency Department Physician.

Date:	Time:	Employee Signature: _____
Date:	Time:	Name of Licensed Personnel Providing Medical Evaluation: _____