UNIVERSITY OF ROCHESTER
UNIVERSITY HEALTH SERVICE

Health Profession Student
RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE
N95, PAPR, or ½ Face Respirator

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

Part A. Section 1.  The following information must be provided by those who have been selected to use any of the above types of respirators (please print).

1. Today's date: ________________
2. Your name: ______________________
3. Your Employee/UR ID # or other institution name and ID #: ____________________________
4. Date of Birth: ________________  Sex: ☐ Male ☐ Female
7. Your job title/student status: ________________________ Unit/Dept. _____________________
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the area code): ________________________  Pager: ____________________
9. The best time to call you at this number: ________________

10. Check the type of respirator you will use on this job/internship (you can check more than one category):
   a) ☐ N, R, or P disposable respirator (filter-mask, i.e. TB mask (N95), non-cartridge type only).
   b) ☐ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus – for those with facial beards, especially).

11. Have you been fit tested or worn a respirator before? ☐ Yes ☐ No
    If yes, what type(s): ________________________________

12. List chronic medical problems: ________________________________ ☐ None

13. List any medications you currently take: ________________________________ ☐ None

______________________________________________________________________________
Part A. Section 2. Questions 1 through 9 below must be answered by those who have been selected to use any of the above types of respirators (please check “yes” or “no”).

1. Do you CURRENTLY smoke tobacco, or have you smoked tobacco in the last month? 1. ☐ Yes ☐ No
   If yes, what (cigarettes, cigars, pipe etc) and # per day: ________________________________________________________________________________

2. Have you ever had any of the following conditions?
   a) Seizures (fits): 2. a) ☐ Yes ☐ No
   b) Diabetes (sugar disease): b) ☐ Yes ☐ No
   c) Allergic reactions that interfere with your breathing: c) ☐ Yes ☐ No
   d) Claustrophobia (fear of closed-in places): d) ☐ Yes ☐ No
   e) Trouble smelling odors: e) ☐ Yes ☐ No

   Explain Yes response ________________________________________________________

3. Have you ever had any of the following pulmonary or lung problems?
   a) Asbestosis: 3. a) ☐ Yes ☐ No
   b) Asthma: b) ☐ Yes ☐ No
   c) Chronic bronchitis: c) ☐ Yes ☐ No
   d) Emphysema: d) ☐ Yes ☐ No
   e) Pneumonia: e) ☐ Yes ☐ No
   f) Tuberculosis: f) ☐ Yes ☐ No
   g) Silicosis: g) ☐ Yes ☐ No
   h) Pneumothorax (collapsed lung): h) ☐ Yes ☐ No
   i) Lung cancer: i) ☐ Yes ☐ No
   j) Broken ribs: j) ☐ Yes ☐ No
   k) Any chest injuries or surgeries: k) ☐ Yes ☐ No
   l) Any other lung problem that you’ve been told about: l) ☐ Yes ☐ No

   Explain Yes response ________________________________________________________

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   a) Shortness of breath: 4. a) ☐ Yes ☐ No
   b) Shortness of breath when walking fast on level ground or walking up a slight hill or incline: b) ☐ Yes ☐ No
   c) Shortness of breath when walking with other people at an ordinary pace on level ground: c) ☐ Yes ☐ No
   d) Have to stop for breath when walking at your own pace on level ground: d) ☐ Yes ☐ No
   e) Shortness of breath when washing or dressing yourself: e) ☐ Yes ☐ No
   f) Shortness of breath that interferes with your job: f) ☐ Yes ☐ No
   g) Coughing that produces phlegm (thick sputum): g) ☐ Yes ☐ No
   h) Coughing that wakes you early in the morning: h) ☐ Yes ☐ No
   i) Coughing that occurs mostly when you are lying down: i) ☐ Yes ☐ No
   j) Coughing up blood in the last month: j) ☐ Yes ☐ No
   k) Wheezing: k) ☐ Yes ☐ No
   l) Wheezing that interferes with your job: l) ☐ Yes ☐ No
   m) Chest pain when you breathe deeply: m) ☐ Yes ☐ No
   n) Any other symptoms that you think may be related to lung problems: n) ☐ Yes ☐ No

   Explain Yes response ________________________________________________________

5. Have you ever had any of the following cardiovascular or heart problems?
   a) Heart attack: 5. a) ☐ Yes ☐ No
   b) Stroke: b) ☐ Yes ☐ No
   c) Angina: c) ☐ Yes ☐ No
   d) Heart failure: d) ☐ Yes ☐ No
   e) Swelling in your legs or feet (not caused by walking): e) ☐ Yes ☐ No
   f) Heart arrhythmia (heart beating irregularly): f) ☐ Yes ☐ No
   g) High blood pressure: g) ☐ Yes ☐ No
   h) Any other heart problem that you’ve been told about: h) ☐ Yes ☐ No

   Explain Yes response ________________________________________________________
6. Have you ever had any of the following cardiovascular or heart symptoms:
   a) Frequent pain or tightness in your chest: 6. a) ☐ Yes ☐ No
   b) Pain or tightness in your chest during physical activity: b) ☐ Yes ☐ No
   c) Pain or tightness in your chest that interferes with your job: c) ☐ Yes ☐ No
   d) In the past two years, have you noticed your heart skipping or missing a beat: d) ☐ Yes ☐ No
   e) Heartburn or indigestion that is not related to eating: e) ☐ Yes ☐ No
   f) Any other symptoms that you think may be related to heart or circulation problems: f) ☐ Yes ☐ No

Explain Yes response
_________________________________________________________________________________

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

Explain Yes response
_________________________________________________________________________________

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 box and go to question 9) ☐
   a) Eye irritation: 8. a) ☐ Yes ☐ No
   b) Skin allergies or rashes: b) ☐ Yes ☐ No
   c) Anxiety: c) ☐ Yes ☐ No
   d) General weakness or fatigue: d) ☐ Yes ☐ No
   e) Any other problem that interferes with your use of a respirator: e) ☐ Yes ☐ No

Explain Yes response
_________________________________________________________________________________

9. Do you have a full face beard, or facial hair extending to the neckline? 9. ☐ Yes ☐ No

10. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? 10. ☐ Yes ☐ No

Explain Yes response
_________________________________________________________________________________

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Student’s Licensed Healthcare Provider (MD, DO, NP, PA) Certification

I have reviewed this information with the student and certify that the information above is correct. Based on that:
☐ I believe this student should be medically cleared for wearing N95 type respiratory protection.
☐ I do not believe this student should be medically cleared for wearing N95 type respiratory protection.

Licensed Provider Signature and credentials

Date

Licensed Provider Name and Credential (Please Print)

Telephone Number, including area code
Name: ___________________________ D.O.B.: _____/_____/______

FOR UHS USE ONLY:

☐ 1.) MEDICALLY CLEARED
   Provider: ___________________ Date __/____/____

☐ 2.) NOT MEDICALLY CLEARED PENDING FURTHER INFORMATION
   Provider: ___________________ Date __/____/____

☐ 3.) NOT MEDICALLY CLEARED PENDING PHYSICAL ASSESSMENT
   Provider: ___________________ Date __/____/____
   ☐ 3a) Respirator Physical
   ☐ 3b) Pulmonary Function Test
   ☐ 3c) Electrocardiogram

**Physician Comment:______________________________________________________________

__________________________________________________________________________

RESPIRATOR TYPE:  ☐ N95: TECNOL  SIZE:  ☐ Small  ☐ Regular
                     ☐ N95: 3M 8512 (One size)
                     ☐ N95: Other Mask ___________ SIZE: ______________
                     ☐ Cartridge  Model ______________________________________
                        ☐ Half face _____________________ SIZE: ______
                        ☐ Full face ______________________ SIZE: ______

☐ PAPR initial training
☐ PAPR annual medical clearance

UHS PROVIDER SIGNATURE: ___________________________ DATE: ______________________

I have reviewed the Information Fact Sheet on the TB Respirator Mask, PAPR, or cartridge. I understand the use, limitations, and care of NIOSH-Approved N95 Particulate Respirator Mask, and/or PAPR. TB education has been reviewed and I have had an opportunity to ask questions.

Employee/student/resident name (please print): ___________________________ Date of birth ______

SIGNATURE: _________________________________________________________________

Unit/Dept: ________________


Updated 3/26/12