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□ Reviewed and Cleared _____ Initials

□ Need to check questions

□ Comments

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
5. Your height: _____ ft. _____ in. 6. Your weight: _____ lbs.
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:_____

Reference:http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9783

Updated 3/26/12