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□ Reviewed and Cleared _____ Initials
□ Need to check questions
□ Comments

UNIVERSITY OF ROCHESTER
UNIVERSITY HEALTH SERVICE

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE
N95, PAPR, or ½ Face Respirator

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

To Employee: Can you read? ☐ **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 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 #: _____
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. Do you know how to contact the health care professional who will review this questionnaire? ❒ Yes ❒ No
    (Call University Health Service, 275-4955)
11. Check the type of respirator you will use on this job (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).
12. Have you worn a respirator? ❒ Yes ❒ No
    If yes, what type(s): _____
13. **List chronic medical problems:**_____ _____ ❒ None

_____

14. **List any medications you currently take**:_____ ❒ None

_____

Part A. Section 2. (Mandatory) 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_____

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**: **Halyard** 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**

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 7/2/19