

UNIVERSITY OF ROCHESTER  
UNIVERSITY HEALTH SERVICE

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE  
N95, PAPR, or 1/2 Face Respirator

UHS OFFICE USE ONLY

- Reviewed and Cleared  
\_\_\_\_\_ Initials
- Need to check questions
- Comments

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? 2. a)  Yes  No

a) Seizures (fits):	b) <input type="checkbox"/> Yes <input type="checkbox"/> No
b) Diabetes (sugar disease):	c) <input type="checkbox"/> Yes <input type="checkbox"/> No
c) Allergic reactions that interfere with your breathing:	d) <input type="checkbox"/> Yes <input type="checkbox"/> No
d) Claustrophobia (fear of closed-in places):	e) <input type="checkbox"/> Yes <input type="checkbox"/> No
e) Trouble smelling odors:	

**Explain Yes response** \_\_\_\_\_

3. Have you ever had any of the following pulmonary or lung problems? 3. a)  Yes  No

a) Asbestosis:	b) <input type="checkbox"/> Yes <input type="checkbox"/> No
b) Asthma:	c) <input type="checkbox"/> Yes <input type="checkbox"/> No
c) Chronic bronchitis:	d) <input type="checkbox"/> Yes <input type="checkbox"/> No
d) Emphysema:	e) <input type="checkbox"/> Yes <input type="checkbox"/> No
e) Pneumonia:	f) <input type="checkbox"/> Yes <input type="checkbox"/> No
f) Tuberculosis:	g) <input type="checkbox"/> Yes <input type="checkbox"/> No
g) Silicosis:	h) <input type="checkbox"/> Yes <input type="checkbox"/> No
h) Pneumothorax (collapsed lung):	i) <input type="checkbox"/> Yes <input type="checkbox"/> No
i) Lung cancer:	j) <input type="checkbox"/> Yes <input type="checkbox"/> No
j) Broken ribs:	k) <input type="checkbox"/> Yes <input type="checkbox"/> No
k) Any chest injuries or surgeries:	l) <input type="checkbox"/> Yes <input type="checkbox"/> No
l) Any other lung problem that you've been told about:	

**Explain Yes response** \_\_\_\_\_

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness? 4. a)  Yes  No

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

**Explain Yes response** \_\_\_\_\_

5. Have you ever had any of the following cardiovascular or heart problems? 5. a)  Yes  No

a) Heart attack:	b) <input type="checkbox"/> Yes <input type="checkbox"/> No
b) Stroke:	c) <input type="checkbox"/> Yes <input type="checkbox"/> No
c) Angina:	d) <input type="checkbox"/> Yes <input type="checkbox"/> No
d) Heart failure:	e) <input type="checkbox"/> Yes <input type="checkbox"/> No
e) Swelling in your legs or feet (not caused by walking):	f) <input type="checkbox"/> Yes <input type="checkbox"/> No
f) Heart arrhythmia (heart beating irregularly):	g) <input type="checkbox"/> Yes <input type="checkbox"/> No
g) High blood pressure:	h) <input type="checkbox"/> Yes <input type="checkbox"/> No
h) Any other heart problem that you've been told about:	

**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) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) Pain or tightness in your chest during physical activity:                          | b) <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| c) Pain or tightness in your chest that interferes with your job:                     | c) <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| d) In the past two years, have you noticed your heart skipping or missing a beat:     | d) <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| e) Heartburn or indigestion that is not related to eating:                            | e) <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| f) Any other symptoms that you think may be related to heart or circulation problems: | f) <input type="checkbox"/> Yes <input type="checkbox"/> No    |

**Explain Yes response** \_\_\_\_\_

7. Do you currently take medication for any of the following problems?

- |                                |  |
|--------------------------------|--|
| a) Breathing or lung problems: | 7. a) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) Heart trouble:              | b) <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| c) Blood pressure:             | c) <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| d) Seizures (fits):            | d) <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) Skin allergies or rashes:  | b) <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| c) Anxiety:   | c) <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| d) General weakness or fatigue:                                     | d) <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| e) Any other problem that interferes with your use of a respirator: | e) <input type="checkbox"/> Yes <input type="checkbox"/> 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](http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9783)

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