ST PETER'S HEALTH PARTNERS

OSHA Respirator Medical Evaluation Questionnaire

Section 1910.134, Appendix C (Mandatory)

Part A. Section I. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator.

Can you read (circle one): Yes No **Please Print when filling out this form**

Today's Date:_____ Name:_____ Time:_____ AM PM

Your age (to the nearest year): _____ Sex (circle one): Male Female Your height _____ft _____in

Your weight _____lbs. Your job title:_____ Work Site: _____

Department:_____ A phone number where you can be reached by the health care professional who reviews this questionnaire (include the area code) _____- _____-_____ Best time to phone you at this number _____ AM PM

Check the type of respirator you will use (you can check more than one category): a. ____N95 Mask b. _____ PAPRS (powered-air purifying respirator)

Have you worn a respirator (circle one): Yes No If yes, what type(s):_____ Date of Hire _____

Employee Health Service are the healthcare professionals who will review this questionnaire.

Please call and ask to speak to one of the RNs for any questions or concerns at in Albany 518-525-2360 or Troy 518-326-7150.

Part A. Section II. (Mandatory)

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (Please check yes or no)

Yes	No	
		1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month?
		2. Have you **ever had** any of the following conditions?
		a. Seizures (fits)
		b. Diabetes (sugar disease)
		c. Allergic reactions that interfere with your breathing
		d. Claustrophobia (fear of closed-in places)
		e. Trouble smelling odors
		3. Have you **ever had** any of the following pulmonary or lung problems?
		a. Asbestosis
		b. Asthma
		c. Chronic bronchitis
		d. Emphysema
		e. Pneumonia
		f. Tuberculosis
		g. Silicosis
		h. Pneumothorax (collapsed lung)
		i. Lung cancer
		j. Broken ribs
		k. Any chest injuries or surgeries
		l. Any other lung problem that you've been told about
		4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?
		a. Shortness of breath
		b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
		c. Shortness of breath when walking with other people at an ordinary pace on level ground
		d. Have to stop for breath when walking at your own pace on level ground
		e. Shortness of breath when washing or dressing yourself
		f. Shortness of breath that interferes with your job
		g. Coughing that produces phlegm (thick sputum)
		h. Coughing that wakes you early in the morning
		i. Coughing that occurs mostly when you are lying down
		j. Coughing up blood in the last month
		k. Wheezing
		l. Wheezing that interferes with your job
		m. Chest pain when you breathe deeply

Yes	No	
		n. Any other symptoms that you think may be related to lung problems
		5. Have you **ever had** any of the following cardiovascular or heart problems?
		a. Heart attack
		b. Stroke
		c. Angina
		d. Heart failure
		e. Swelling in your legs or feet (not caused by walking)
		f. Heart arrhythmia (heart beating irregularly)
		g. High blood pressure
		h. Any other heart problem that you've been told about
		6. Have you **ever had** any of the following cardiovascular or heart symptoms?
		a. Frequent pain or tightness in your chest
		b. Pain or tightness in your chest during physical activity
		c. Pain or tightness in your chest that interferes with your job
		d. In the past two years, have you noticed your heart skipping or missing a beat
		e. Heartburn or indigestion that is not related to eating
		f. Any other symptoms that you think may be related to heart or circulation problems
		7. Do you **currently** take medication for any of the following problems?
		a. Breathing or lung problems
		b. Heart trouble
		c. Blood pressure
		d. Seizures (fits)
		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 space and go to question 9)
		a. Eye irritation
		b. Skin allergies or rashes
		c. Anxiety
		d. General weakness or fatigue
		e. Any other problem that interferes with your use of a respirator
		9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

I certify the above information correct. Signature_____

TO BE COMPLETED BY EMPLOYEE HEALTH SERVICES ONLY

Mask Fit Test

☐ Approved ☐ Denied N,R or P disposable respirator (filter-mask, non-cartridge type only).

☐ Approved ☐ Denied ☐ N/A for: Other types (i.e. half- or full-face piece type, powered-air purifying)

_____ _____

Employee Health Service Clinician Signature/ Title or Designee Clinician Signature/Title Date