Respirator Medical Evaluation Questionnaire – N95 (Respiratory Isolation Mask) (1/3/07)

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

To the employee: Can you read? (circle one): 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 every employee who has been selected to use any type of respirator (please print).

Name: ___________________________ Date: _______________
Phone # (where you can be reached by the health care professional who reviews this questionnaire): _____________________
The best time to reach you at this number: ____________________ Alternate #: __________________
Job Title: __________________ Department: __________________ Email: __________________
Employer (check one): □ UCSF Medical Center □ UCSF Campus □ LPPI □ Traveler □ Other __________
Age (to nearest year): ___________ Sex: □Male □Female Height: _______ Weight: _______ lbs.
Birthdate: mm/dd/yy ____________________

1. Has your employer told you how to contact the health care professional who will review this questionnaire? (choose one) □Yes □No
2. Have you worn a respirator? (choose one) □Yes □No
   If “yes”, what type(s) ________________________________

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please indicate “yes” or “no”).

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? □Yes □No

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

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

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

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

6. Have you currently taken medication for any of the following problems?
   a) Breathing or lung problems □ Yes □ No
   b) Heart trouble □ Yes □ No
   c) Blood pressure □ Yes □ No
   d) Seizures (fits) □ Yes □ No
   If “yes, name the medications if you know them: ________________________________

8. If you have used a respirator, have you ever had any of the following problems? (If you have never used a
   respirator, check the following space and go to question 9) □ Yes □ No
   a) Eye irritation □ Yes □ No
   b) Skin allergies or rashes □ Yes □ No
   c) Anxiety □ Yes □ No
   d) General weakness or fatigue □ Yes □ No
   e) Any other problem that interferes with your use of a respirator □ Yes □ No

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

ASSessment – To be completed by a nurse or physician in employee health services

☐ Employee is cleared to perform job duties with use of a respirator
☐ Employee needs an appointment with Employee Health Services for further evaluation
Other recommendations: ________________________________

Employee Health RN/NP/MD Signature _____________________________ Date __________________
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