

House Officer OSHA Respirator Medical Evaluation Questionnaire

Instructions: This form should be completed, signed, and returned to your Program Coordinator with your New Hire paperwork. To maintain your confidentiality, your employer or supervisor must not look at or review your answers. If you wish contact the physician who will review this questionnaire, contact the GME Office.

Part A. Section 1.

1. Today's date: _____ 2. Your name: _____
3. Your age (to the nearest year): _____ 4. Sex (circle one): Male/Female
5. Your height: _____ ft. _____ in. 6. Your weight: _____ lbs. 7. Your job title: House Officer
8. A phone number where you can be reached by the health care professional who reviews this questionnaire: (____) _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes / No
11. Type of respirator to be used: N Type Disposable respirator (filter-mask, non-cartridge type only).
12. Have you worn a respirator (circle one): Yes / No If "yes," what type(s): _____

Part A. Section 2.

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?

YES	NO	
		Seizures (fits)
		Diabetes (sugar disease)
		Allergic reactions that interfere with your breathing
		Claustrophobia (fear of closed-in places)
		Trouble smelling odors

3. Have you **ever had** any of the following pulmonary or lung problems?

YES	NO		YES	NO	
		Asbestosis			Illicosis
		Asthma			Pneumothorax (collapsed Lung)
		Chronic bronchitis			Lung cancer
		Emphysema			Broken ribs
		Pneumonia			Any chest injuries or surgeries
		Tuberculosis			Any other lung problem you've been told about

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

YES	NO	
		Shortness of breath
		Shortness of breath when walking fast on level ground or walking up a slight hill or incline
		Shortness of breath when walking with other people at an ordinary pace on level ground
		Have to stop for breath when walking at you own pace on level ground
		Shortness of breath that interferes with your job
		Shortness of breath when washing or dressing yourself
		Coughing that produces phlegm (thick sputum)
		Coughing that wakes you early in the morning
		Coughing that occurs mostly when you are lying down
		Coughing up blood in the last month
		Wheezing
		Wheezing that interferes with your job
		Chest pain when you breathe deeply
		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?

YES	NO

Heart attack
Stroke
Angina
Heart failure

YES	NO

Swelling in your legs or feet (not caused by waling)
Heart arrhythmia (heart beating irregularly)
High blood pressure
Any other heart problem that you've been told about

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

YES	NO

Frequent pain or tightness in your chest
Pain or tightness in your chest during physical activity
Pain or tightness in your chest that interferes with your job
In the past two years, have you noticed your heart skipping or missing a beat
Heartburn or indigestion that is not related to eating
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?

YES	NO

Breathing or lung problems
Heart trouble

YES	NO

Blood pressure
Seizures (fits)

8. If you've used a respirator, have you **ever had** any of the following problems? (Check all that apply)
(If you've never used a respirator, go to question 9)

YES	NO

Eye irritation
Anxiety
Any other problem that interferes with you use of a respirator

YES	NO

Skin allergies or rashes
General weakness or fatigue

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire:

YES	NO

Physician / Licensed Health Care Provider – Respirator Authorization Use Form

Note: Physician or licensed health care professional will complete this form and completed form will be verified at FIT testing.

Select ONE of the following:

I have reviewed this medical questionnaire and I do not recommend further examination be performed. The employee is authorized to wear N95 Disposable respirator.
(Type / Model)

I have reviewed this medical questionnaire and recommend further examination be performed.

PLHCP Name – Print

Date

PLHCP Signature

House Officer Signature