SSN: XXX-XX-_____

Waco-McLennan County Public Health District
Respiratory Protection Program
OSHA Respirator Medical Evaluation Questionnaire

Section 1: The following information must be provided by every staff person who has been selected to use any type of respirator, and by each program participant who wishes to be fitted for a respirator. (Please print.)

Name: _____ Date: _____

Date of Birth: _____ Sex: (circle one) M / F

Height: _____ ft _____ in Weight: _____ kg

Job Title: _____

Home Address: _____

Phone number you can be reached outside of business hours: _____

Type of respirator you will use: N95 disposable respirator (filter-mask, non-cartridge only)

Have you worn this type of respirator before? (circle one) Yes / No

Section 2: Questions 1 - 9 **MUST** be answered by each program participant. Circle '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	Yes	No
b. Diabetes (type 1 -OR- type 2)	Yes	No
c. Allergic reactions that interfere with your breathing	Yes	No
d. Claustrophobia (fear of closed-in spaces)	Yes	No
e. Trouble smelling odors	Yes	No
3. Have you *ever* had any of the following 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
4. Do you *currently* have any of the following symptoms of 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

4. Continued:

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	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 *ever* had any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest	Yes	No
b. Pain or tightness in your chest during physical activity	Yes	No
c. Pain or tightness in your chest that interferes with your job	Yes	No
d. In the past two years, have you noticed your heart skipping or missing a beat	Yes	No
e. Heartburn or indigestion that is not related to eating	Yes	No
f. Any other symptoms that you think may be related to heart or circulation problems	Yes	No

7. Do you *currently* take 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	Yes	No

8. If you've used a respirator, have you *ever* had any of the following problems? (If you've *never* used a respirator, proceed to the next question)

a. Eye irritation	Yes	No
b. Skin allergies or rashes	Yes	No

8. Continued:

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 your answers? Yes No

Participant Signature: _____ Date: _____

Reviewed by: _____ Date: _____