UNIVERSITY HEALTH SERVICE

Medical Questionnaire for Respirator Mask Usage

Today's Date:	

Note to the evaluator: This questionnaire must be administered to employees in a way that ensure their understanding. Before asking the employee to complete, please ask the following questions and record the employee's response.

Can you read English? Yes No	If you cannot read English, do you speak and understand English? Yes No

If the employee cannot read English, but understands and can speak English, _______________or another evaluator who is not the employee's supervisor may ask the questions and document the employees' responses. If the employee can neither read nor speak English, the evaluator must use an alternative method, suitable to the employee and the situation and document the method used.

Name:	UKID:	Age:
Job Title:	Height: Weight:	Gender:
Department:	Work phone:	Home phone:
Best time to reach you at this number:		
Check the type of respirator you will use: (You can check more than one category)		
	N, R, or P disposable respirator (filter-mask, non-cartridge type only)	
	Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus	
	Have you worn a respirator? If yes, what type(s):	

QUESTIONS:

Question	Response
1. Have you had or do you have any of the following? a. Allergic reactions that interfere with breathing	Yes No
b. Trouble smelling odors	Yes No
c. Seizures (fits)	Yes No
d. Diabetes (sugar disease)	Yes No
e. Claustrophobia (fear of tight or enclosed spaces)	Yes No
2. Have you ever had any of the following lung problems?	Yes No
a. Asbestosis	Yes No
b. Asthma	Yes No
c. Chronic bronchitis	Yes No
d. Emphysema	Yes No
e. Pneumonia	Yes No
f. Tuberculosis (TB)	Yes No
g. Silicosis	Yes No
h. Collapsed lung	Yes No
i. Broken ribs	Yes No
j. Chest injuries or surgeries	Yes No
k. Lung Cancer	
l. Any other lung problem	Yes No
3. Do you have any of the following symptoms?	Yes No
a. Shortness of breath	Yes No
b. Shortness of breath when walking fast on level ground or up a slight incline or hill	Yes No
c. Shortness of breath when walking with other people at a normal 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	Yes No
h. Coughing that wakes you up early in the morning	Yes No
i. Coughing that occurs mostly when you are lying down	Yes No
j. Coughing up blood (within 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 thin may be related to lung problems	Yes No
4. Have you ever had any of the following cardiovascular or heart problems?	Yes No
a. Heart attack	Yes No
b. Stroke	Yes No

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Question	Yes	No
c. Angina	Yes	No
d. Heart failure	Yes	No
e. Swelling in your legs of feet	Yes	No
f. Heart arrhythmia	Yes	No
g. High blood pressure	Yes	No
h. Any other heart problem that you've been told about	Yes	No
5. Have you had any of the following cardiovascular or heart symptoms?	Yes	No
a. Frequent pain or tightness in your chest	Yes	No
b. Pain or tightness in your chest during physical activities	Yes	No
c. Pain or tightness in your chest that interferes with your job	Yes	No
d. Heart skipping or missing a beat (within the last two years)	Yes	No
e. Heartburn or indigestion that is not related to eating	Yes	No
f. Any other cardiovascular or circulatory problems	Yes	No
6. Do you currently take any medication for the following?	Yes	No
a. Breathing or lung problems	Yes	No
b. Heart trouble	Yes	No
c. Blood pressure	Yes	No
d. Seizures (fits)	Yes	No
7. Do you currently smoke or have you smoked in the last month?	Yes	No
8. Have you ever worn a respirator in the past?	Yes	No
9. If so, have you ever had any of the following during respirator use?	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 would interfere with respirator use	Yes	No
10. Has your supervisor told you how to contact the safety officer or health care provider who will review your evaluation?	Yes	No
11. Would you like to talk to the health care provider who will review your evaluation about your answers to these questions?	Yes	No

NOTE: If the employee answered "yes" to any part of questions 1-6 or 9, the evaluation must be reviewed by a licensed health care provider prior to granting approval for respirator use.

Evaluator Use Only	
☐ Approved	☐ Denied
☐ Approved with restrictions. List restrictions:	
Evaluator signature:	Evaluator Name (printed):

THIS MEDICAL EVALUATION HAS BEEN DEVELOPED IN COMPLIANCE WITH OSHA 1910.134, APPENDIX C.

Date of Fit Testing: ______________________ _____ Fit Test Failed

Following a satisfactory fit testing for respirator use, the worker was issued: (check one)

______North/Honeywell brand N95 _____3M 8210 series N95 _____3M 1860 series N95

_____3M 9210 Aura series N95 ______ Kimberly-Clark Tecnol series N95 ______MSA Affinity Plus N95

_____Other (specify brand, type, and size) ____

Please send the completed forms to Leslie Ehrmantraut at University Health Service, room 404A.
Secure Fax: 859-257-9814 Phone: 859-218-3257