**UofL Respiratory Protection Program**

# "N95 Decon PROGRAM"

## Respirator Medical Evaluation Questionnaire

**OSHA 1910.134 Appendix C**

# For use with N95 Decon Program ONLY

Directions:

1. You must answer ALL questions and complete this form electronically.
2. After completing the questionnaire sign using Abode Acrobat signature or by typing your name in the signature line.
3. Click the SEND FOR REVIEW button just below the signature area to submit the form.
4. A copy of the form is automatically emailed to the email address that you provided on the form.

If you have any questions about this medical questionnaire,
please contact your supervisor or the Respiratory Protection Program Administrator
at the Department of Environmental Health and Safety: 852-2961

University of Louisville
Department of Environmental Health & Safety
Modified July 20, 2009
http://louisville.edu/dehs/ohs/respiratory/respiratory.html

# UofL Respiratory Protection Program

## Respirator Medical Evaluation Questionnaire

### OSHA 1910.134 Appendix C

**To the employee:**

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.

The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date: _____

2. Your Name: _____

3. Your Soc. Sec. #:_____ Employee ID #:_____

4. Birth Date_____ Email Address: _____

5. Sex: ❑ Male ❑ Female

6. Your height:_____ ft._____ in.

7. Your weight:_____lbs.

8. Your job title: _____

9. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):_____

10. The best time to phone you at this number: _____

11. ❑ **Yes** ❑ **No** Has your employer told you how to contact the health care professional who will review this questionnaire?

12. Check the type of respirator you will use (you can check more than one category):

❑ **Yes** ❑ **No** N, R, or P disposable respirator (filter-mask, non-cartridge type only)

❑ **Yes** ❑ **No** Other type (for example, half- or full-facemask type, powered-air purifying, supplied-air, self-contained breathing apparatus)

13. ❑ **Yes** ❑ **No** Have you worn a respirator before?

If "yes," what type(s): _____

Name: DOB:

| | |
|---|---|
| **Question 1:** | 1. Do you do any of the following: |
| ❑ Yes ❑ No | a. Do you **currently** smoke or have you smoked tobacco in the last month? |
| ❑ Yes ❑ No | b. Do you vap or have you vapped in the last month? |
| **Question 2:** | 2. Have you ever had: |
| ❑ Yes ❑ No | a. Seizures (fits) |
| ❑ Yes ❑ No | b. Diabetes (sugar disease) |
| ❑ Yes ❑ No | c. Allergic reactions that interfere with your breathing |
| ❑ Yes ❑ No | d. Claustrophobia (fear of closed-in places) |
| ❑ Yes ❑ No | e. Trouble smelling odors |
| **Question 3:** | 3. Have you ever had any of the following pulmonary or 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 |
| ❑ 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: _____ |
| **Question 4:** | 4. Do you **currently** have any of the following symptoms of pulmonary or lung illness? |
| ❑ Yes ❑ No | 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 when walking or climbing stairs. |
| ❑ Yes ❑ No | g. Coughing that produces phlegm (thick sputum) |

Name: DOB:

| | |
|---|---|
| **Question 5:** | Do you have any of the following? |
| ❑ Yes ❑ No | d. General weakness or fatigue |
| ❑ Yes ❑ No | e. Any other problem that interferes with your use of a respirator or mask<br>If yes, please list:<br>_____ |
| **Question 6:** | Do you have any other medical conditions not noted above? |
| ❑ Yes ❑ No | If yes, please list:<br>_____ |
| **Question 7:** | Do you have any **ALLERGIES** to any of the following? |
| ❑ Yes ❑ No | a. Medications?<br>If yes, please list: _____ |
| ❑ Yes ❑ No | b. Animals such as dogs, cats, mice or rats?<br>If yes, please list reaction to each type of animal to which you are allergic:<br>Animal Reaction<br>_____ _____<br>_____ _____<br>_____ _____ |
| ❑ Yes ❑ No | c. Latex?<br>If yes, please list reaction_____ |
| ❑ Yes ❑ No | d. Other environmental allergies (soaps, metals, preservatives, etc)?<br>If yes, please list: _____ |
| **Question 8:** | |
| ❑ Yes ❑ No | a. Do you have any conditions that you take prescription or over-the-counter medications routinely?<br>If yes, please list each condition and the associated medications<br>_____ _____<br>_____ _____<br>_____ _____ |
| ❑ Yes ❑ No | a. Immunosuppressive or immunomodulating medication such as Stelara®, Remicade®, etc? (Also known as MAB drugs)<br>If yes, please list the names of the medicines:_____ |
| ❑ Yes ❑ No | Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? |

| | | | |
|---|---|---|---|
| **Employee Signature:** | | **Date:** | |
| **Medical Reviewer Signature:** | | **Date:** | |

**Clear Form** **Save and Clear Form** **Submit Form**

If you have any questions about this medical questionnaire, please contact your supervisor or the Respiratory Protection Program Administrator at the Department of Environmental Health and Safety: 852-2961