OCCUPATIONAL HEALTH SERVICES

THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER

University Health Services
910 Madison Ave, Suite 922
Memphis, Tennessee 38163
901-448-5630 Office
901-448-7255 Fax

OSHA Respirator Medical Evaluation Questionnaire

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**).

1. **Today's date**: _____ 2. **Your name:** _____

3. **Your D.O.B.** _____ 4. **Sex** (check one): Female ☐ Male ☐

5. **Your height**: _____ft_____in 6. **Your weight**: _____lbs

7. **School and Year(**ex:Medicine 2nd year) _____

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

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

	Yes	No
10. Has your employee health told you how to contact the health care professional who will review this questionnaire		

	Yes	No
11. Check the type of respirator you will use (you can check more than one category):		
a. N, R, or P disposable respirator (filter-mask, non- cartridge type only).		
b. other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).		

Yes	No

12. Have you worn a respirator
If "yes," what type(s): Full face, half-face, N / P -95, SCBA

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 (**put x in box under "yes"** or "**no**").

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

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

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

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?	Yes	No
a) Shortness of breath		
b) Shortness of breath when walking fast on level ground or walking up a Slight hill or incline		
c) Shortness of breath when walking with other people at an ordinary pace on level ground:		
d) Have to stop for breath when walking at your own pace on level ground		
e) Shortness of breath when washing or dressing yourself		
f) Shortness of breath that interferes with your job		
g) Coughing that produces phlegm (thick sputum)		
h) Coughing that wakes you early in the morning		
i) Coughing that occurs mostly when you are lying down		
j) Coughing up blood in the last month		
k) Wheezing		
l) Wheezing that interferes with your job		
m) Chest pain when you breathe deeply		
n) 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
a. Heart attack		
b. Stroke		
c. Angina		
d. Heart failure		
e. Swelling in your legs or feet (not caused by walking)		
f. Heart arrhythmia (heart beating irregularly)		
g. High blood pressure		
h. 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
a. Frequent pain or tightness in your chest		
b. Pain or tightness in your chest during physical activity		
c. Pain or tightness in your chest that interferes with your job		
d. In the past two years, have you noticed your heart skipping or missing a beat		
e. Heartburn or indigestion that is not related to eating		
f. 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
a. Breathing or lung problems		
b. Heart trouble		
c. Blood pressure		
d. Seizures (fits)		

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

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

Regulations (Standards - 29 CFR)
OSHA Respirator Medical Evaluation Questionnaire (Mandatory). - 1910.134 App C

4/8/13/UHS

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I have provided the correct information to the best of my abilities. My forms were review by a health care provider from UTHSC and I was made aware of the nature and purpose for getting a fit test.

Signed_____Date_____
Student

Signed_____Date_____
University Health Provider

Signed_____Date_____
Fit Test Administrator