Appendix A
Medical Questionnaire & Cover Sheet

Respirator Medical Evaluation Questionnaire
Adapted from Appendix C to Sec. 1910.134: OSHA

To meet the requirements in the Dartmouth College Respiratory Protection Program, you must complete the following questionnaire annually, after which it will be reviewed by a licensed clinical provider at the Dartmouth College Health Service (Dick's House).

INSTRUCTIONS: Fully complete Section A below as well as the attached medical questionnaire.

Section A

Name:

Dept: **Supervisor:** _____

Email: **Phone:**

Type of respirator/s worn – check all that apply: ☐ **Filtering facepiece (N95)**

☐ **Tight fitting half face** ☐ **Tight fitting full face**
☐ **Powered Air Purifying Respirator** ☐ **Other:** _____

Job description while wearing respirator, to include estimated frequency and duration, expected airborne hazards:

A licensed healthcare provider will review the completed medical questionnaire. If you have questions or wish to discuss this evaluation, please call Dick's House at 603-646-9400.

Healthcare Provider Use Only (Return form to EHS prior to fit test)

◯ This individual is medically able to wear a respiratory device at this time.

◯ This individual is NOT medically able to wear a respiratory device at this time.

Health service provider signature: _____

Date of review: _____

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Respiratory Protection Program, OSHA Mandatory Medical Questionnaire

1. Today's date:

2. Name (last, first, MI)	3. Date of Birth	4. Sex	5. Height ft in

6. Weight Lbs.	7. Job title	8. Phone number where you can be reached by the health care professional who will review this questionnaire (include area code)	9. Best time to reach you at this number

10. Has your employer told you how to contact the health care provider who will review this questionnaire? ☐ yes ☐ no	11. Type(s) of respirator you will use (mark all that apply): a. ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only) b. ☐ other type (for example, half- or full-facepiece type, powered-air purifying, supplied air, self contained breathing apparatus	12. Have you worn a respirator? ☐ yes ☐ no If yes, what type(s)

Medical History	YES	NO
Questions 1 through 9 below must be answered by every Employee who has been selected to use any type respirator. Please mark "X" yes or no for each.		
1. Do you currently smoke tobacco, or have you smoked tobacco during the past month?	☐	☐
2. Have you ever had any of the following conditions?	☐	☐
a. seizures (fits, convulsions, epilepsy)	☐	☐
b. diabetes (high blood sugar disease)	☐	☐
c. allergic reactions that interfere with your breathing	☐	☐
d. claustrophobia (fear of closed-in places)	☐	☐
e. trouble smelling odors	☐	☐
f. latex (rubber) allergy	☐	☐
3. Have you ever had any of the following pulmonary (lung) conditions?		
a. asbestosis	☐	☐
b. asthma	☐	☐
c. chronic bronchitis	☐	☐
d. emphysema	☐	☐
e. pneumonia	☐	☐
f. tuberculosis	☐	☐
g. silicosis	☐	☐
h. beryllium disease	☐	☐
i. sarcoidosis	☐	☐
j. pneumothorax (collapsed lung)	☐	☐
k. lung cancer	☐	☐
l. broken ribs	☐	☐
m. any chest injury or surgeries	☐	☐
n. any other lung problem that you've told about	☐	☐
4. Do you currently have any of the following symptoms of pulmonary or lung disease?		
a. shortness of breath	☐	☐
b. shortness of breath when walking fast on level ground or walking normal speed 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	☐	☐

Medical History continued	YES	NO
g. coughing that produces phlegm (thick sputum)	☐	☐
h. coughing that wakes you up 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 (heart) problems?		
a. heart attack	☐	☐
b. stroke	☐	☐
c. angina (heart pain)	☐	☐
d. heart failure	☐	☐
e. swelling in you legs or feet (not caused by walking)	☐	☐
f. heart arrhythmia (irregular heart beat)	☐	☐
g. high blood pressure	☐	☐
h. abnormal stress test -- approximate date:	☐	☐
i. cardiac (heart) catheterization – approximate date:	☐	☐
j. any other heart problem about which you have been told	☐	☐
6. Have you ever had any of the following cardiovascular (heart) symptoms?		
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 any medication for any of the following problems?		
a. breathing	☐	☐
b. heart trouble	☐	☐
c. blood pressure	☐	☐
d. seizures (fits, convulsions, epilepsy)	☐	☐

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Medical History continued	YES	NO
Have you ever used a respirator? (If NO, skip to question 9.)	☐	☐
8. If you have used a respirator, have you ever had any of the following problems?		
a. eye irritation	☐	☐
b. skin allergies or rashes	☐	☐
c. anxiety (caused by wearing respirator)	☐	☐
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 healthcare professional who will review this questionnaire about your answers?	☐	☐
Answer questions 10 through 15 below only if you use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA)		
10. Have you ever lost vision in either eye (temporarily or permanently)?	☐	☐
11. Do you currently have any of the following vision problems?		
a. wear contact lenses	☐	☐
b. wear glasses	☐	☐
c. color blind	☐	☐
d. any other eye or vision problems	☐	☐
12. Have you ever had an injury to your ears, including a broken ear drum?	☐	☐
13. Do you currently have any of the following hearing problems?	☐	☐
a. difficulty hearing	☐	☐
b. wear a hearing aid	☐	☐
c. any other hearing or ear problem	☐	☐
14. Have you ever had a back injury?	☐	☐
15. Do you currently have any of the following musculoskeletal problems?		
a. weakness in your arms, legs, hands, or feet	☐	☐
b. back pain	☐	☐
c. pain or stiffness when you lean forward or backward at the waist	☐	☐
d. difficulty fully moving your arms and legs	☐	☐
e. difficulty moving your head up or down	☐	☐
f. difficulty moving your head side-to-side	☐	☐
g. difficulty bending at your knees	☐	☐
h. difficulty squatting to the ground	☐	☐
i. difficulty climbing a flight of stairs or a ladder carrying more than 25 pounds	☐	☐
j. any other muscle or skeletal problem that interferes with using a respirator	☐	☐
16. Any other health condition that you think may affect your ability to use a respirator safely? If YES, please specify condition:	☐	☐
Signature of worker:		

Medical Clinic Use Only:	YES	NO
Medically fit to wear respirator *Any positive responses to questions 1-8 of the Medical History portion or physician's recommendation require a follow-up medical examination.	☐	☐
Referred for further evaluation If, YES, specify condition or concern:	☐	☐

Reviewed by: _____

Date:

Examiner's comments on positive responses:

Targeted physical exam (performed upon physician's recommendation):

BP:_____/_____ Pulse:_____ ☐ Reg ☐ Irreg

	Normal	Abn
HEENT	☐	☐
Neck – incl. carotid upstrokes and JVD	☐	☐
Lungs	☐	☐
Heart	☐	☐
Extremities – incl. peripheral pulses and edema	☐	☐
Other – specify:	☐	☐

Medically fit to wear respirator?	☐ Yes	☐ No