Penn Medicine
Chester County Hospital

Occupational Health Center
and Travel Medicine Program

OSHA Medical Questionnaire for Respirator Clearance

1. Today's date ____
2. Your name ____
3. Your age (to nearest year) ________
4. Sex _____ Male _____ Female
5. Your height _____ feet _____ inches
6. Your weight __________ pounds
7. Your job title __________________________________
8. A phone number where you can be reached by the health-care professional who reviews this questionnaire (include area code) ______________________________
9. The best time to phone you at this number__________________
10. Has your employer told you how to contact the health-care professional who will review this questionnaire? ___ Yes ___ No
11. Would you like to talk with the health-care professional who will review this questionnaire about your answers to this questionnaire? ___ Yes ___ No

12. **Check the type of respirator you will use** (check all that apply)

_____ N-, R-, or P-disposable respirator **Complete Front only**
(filter-mask, noncartridge type only)

_____ Other type s **Complete Front and Back**
(half- or full-facepiece type, powered-air purifying, supplied air, or self-contained breathing apparatus)

13. Have you worn a respirator? _____ Yes _____ No
If "yes," what types? ________________________________

Yes No **Questionnaire for Users of N95 Respirators**

1. Do you currently or have you smoked tobacco during the previous
___ ___ month? If "yes"
a. At what age did you start smoking? _____________
b. How long ago did you quit smoking? ____________
c. How many packs per day did /do you smoke? _____

2. Have you ever had any of the following conditions?
___ ___ 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?
___ ___ a. Asbestosis
___ ___ b. Asthma
___ ___ c. Chronic bronchitis
___ ___ d. Emphysema
___ ___ e. Pneumonia
___ ___ f. Tuberculosis
___ ___ g. Silicosis
___ ___ h. Pneumothorax (collapsed lung)
___ ___ i. Lung cancer
___ ___ j. Broken ribs
___ ___ k. Any chest injuries or surgeries
___ ___ l. Any other lung problems_____________________

Yes No (*Continued*)

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
___ ___ a. Shortness of breath
___ ___ b. Shortness of breath when walking quickly 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 primarily 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 might be related to lung problems

5. Have you ever had any of the following cardiovascular or heart problems?
___ ___ 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_______________________

6. Have you ever had any of the following cardiovascular or 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 previous 2 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 might be related to heart or circulation problems

7. Do you currently take medication for any of the following problems?
___ ___ a. Breathing or lung problems
___ ___ b. Heart trouble
___ ___ c. Blood pressure
___ ___ d. Seizures (fits)

8. If you have used a respirator, have you ever had any of the following problems? (If you have never used a respirator, check here ___ and go to question 9.)
___ ___ 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. Are you currently taking any medications?
___ ___ If yes, list here__________________________________
____
____

Questionnaire for full face or SCBA respirators

Questions 10 to 15 *must* be answered by every employee who has been selected to wear either a full-facepiece or a self-contained breathing apparatus. For employees who have been selected to use other types of respirators, answering these questions is voluntary.

Yes No

10. Have you ever lost vision in either eye (temporary or permanently)?

____ ____

11. Do you currently have any of the following vision problems?

____ ____ Wear contact lenses
____ ____ Wear glasses
____ ____ Color blind
____ ____ 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?

____ ____ Difficulty hearing
____ ____ Wear a hearing aid
____ ____ 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?
____ ____ Weakness in any of your arms, hands, legs or feet
____ ____ Back pain
____ ____ Difficulty fully moving your arms and legs
____ ____ Pain or stiffness when you lean forward or backward at the waist
____ ____ Difficulty fully moving your head up or down
____ ____ Difficulty fully moving your head side to side
____ ____ Difficulty bending at your knees
____ ____ Difficulty squatting to the ground
____ ____ Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs
____ ____ Any other muscle/skeletal problem that interferes with using a respirator.

____

Patient Signature

***********************Do not write below this line For Office use Only*******************************

Evaluator assessment: Questionnaire reviewed and ________Cleared for Respirator use _________Deferred pending exam

Evaluator Name Signature Date

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