

Respirator Medical Evaluation Expanded Questionnaire

(Expanded from [OSHA Respirator Medical Evaluation Questionnaire](#))

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of part A, do not require a medical examination.

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.

To licensed healthcare professional reviewing the questionnaire: The expanded questions are added to obtain more information on specific medical conditions. Licensed healthcare professional may consider obtaining additional information (beyond what is included in this expanded questionnaire), as deemed necessary for their assessment.

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 age (to nearest year): _____

4. Sex (circle one): Male/Female

5. Your height: _____ ft. _____ in.

6. Your weight: _____ lbs.

7. Your job title: _____

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: _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): 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-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): Yes/No

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

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 (please circle "yes" or "no").

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

2. Have you **ever had** any of the following conditions?

a. Seizures: Yes/No

- **If yes for history of seizure, is this still an active condition for you (i.e. you experience seizures periodically or are considered at risk for having more seizures in future)?**

b. Diabetes (sugar disease): Yes/No

- **If yes, it is uncontrolled?**

c. Allergic reactions that interfere with your breathing: Yes/No

- **If yes, was the allergy related to any chemicals or materials used for respiratory fit testing or an N95 mask or other respirator?**

d. Claustrophobia (fear of closed-in places): Yes/No

- **If yes, does your claustrophobia interfere with your ability to wear an N95 mask or another respirator?**

e. Trouble smelling odors: Yes/No

- (Note: If yes, quantitative fit test (QNFT) protocol to be used if available; otherwise, qualitative fit test (QLFT) protocol can be used if individual can smell solution.)

3. Have you **ever had** any of the following pulmonary or lung problems?

a. Asbestosis: Yes/No

b. Asthma: Yes/No

- **If yes:**
 - **Have you experienced frequent exacerbation of your asthma in the last couple of years?**
 - **Does asthma interfere with your ability to wear an N95 mask or another respirator?**

c. Chronic bronchitis*: Yes/No

- **If yes:**
 - **Have you experienced frequent exacerbation of your chronic bronchitis in the last couple of years?**
 - **Does chronic bronchitis interfere with your ability to wear an N95 mask or another respirator?**
- (Note: **Chronic bronchitis is a clinical diagnosis characterized by a cough productive of sputum for over three months' duration during two consecutive years and the presence of airflow obstruction.*
<https://www.aafp.org/pubs/afp/issues/1998/0515/p2365.html>)

d. Emphysema: Yes/No

- **If yes:**
 - **Have you experienced frequent exacerbation of your emphysema in the last couple of years?**
 - **Does emphysema interfere with your ability to wear an N95 mask or another respirator?**

e. Pneumonia: Yes/No

- **If yes, are you still experiencing symptoms from your past pneumonia episode?**

f. Tuberculosis: Yes/No

g. Silicosis: Yes/No

h. Pneumothorax (collapsed lung): Yes/No

i. Lung cancer: Yes/No

- **If yes, do you currently have lung cancer and/or currently receiving healthcare for this?**

j. Broken ribs: Yes/No

- **If yes, do you currently have a broken rib(s) and/or currently receiving healthcare for this?**

k. Any chest injuries or surgeries: Yes/No

- **If yes, do you have a current chest injury and/or currently receiving healthcare for a chest injury or surgery?**

l. Any other lung problem that you've been told about: Yes/No

- **If yes, is the lung problem current and/or are you currently receiving healthcare for it?**
 - **If yes, does it interfere with your ability to wear an N95 mask or another respirator?**

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

a. Shortness of breath: Yes/No

- **If yes:**
 - **Is this an issue that has not yet been medically evaluated?**
 - **Does it interfere with your ability to wear an N95 mask or another respirator?**

b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No

- **If yes:**
 - **Is this an issue that has not yet been medically evaluated?**
 - **Does it interfere with your ability to wear an N95 mask or another respirator?**

c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No

- **If yes:**
 - **Is this an issue that has not yet been medically evaluated?**
 - **Does it interfere with your ability to wear an N95 mask or another respirator?**

d. Have to stop for breath when walking at your own pace on level ground: Yes/No

- **If yes:**
 - **Is this an issue that has not yet been medically evaluated?**
 - **Does it interfere with your ability to wear an N95 mask or another respirator?**

e. Shortness of breath when washing or dressing yourself: Yes/No

- **If yes:**
 - **Is this an issue that has not yet been medically evaluated?**
 - **Does it interfere with your ability to wear an N95 mask or another respirator?**

f. Shortness of breath that interferes with your job: Yes/No

g. Coughing that produces phlegm (thick sputum): Yes/No

- **If yes:**
 - **Is this an issue that has not yet been medically evaluated?**
 - **Does it interfere with your ability to wear an N95 mask or another respirator?**

h. Coughing that wakes you early in the morning: Yes/No

- **If yes:**
 - **Is this an issue that has not yet been medically evaluated?**
 - **Does it interfere with your ability to wear an N95 mask or another respirator?**

i. Coughing that occurs mostly when you are lying down: Yes/No

- **If yes:**
 - **Is this an issue that has not yet been medically evaluated?**
 - **Does it interfere with your ability to wear an N95 mask or another respirator?**

j. Coughing up blood in the last month: Yes/No

k. Wheezing: Yes/No

- **If yes:**
 - **Is this an issue that has not yet been medically evaluated?**
 - **Does it interfere with your ability to wear an N95 mask or another respirator?**

l. Wheezing that interferes with your job: Yes/No

m. Chest pain when you breathe deeply: Yes/No

- **If yes:**
 - **Is this an issue that has not yet been medically evaluated?**
 - **Does it interfere with your ability to wear an N95 mask or another respirator?**

n. Any other symptoms that you think may be related to lung problems: Yes/No

- **If yes, are the symptom(s) current and/or are you currently receiving healthcare for it?**
 - **If yes, does it interfere with your ability to wear an N95 mask or another respirator?**

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

a. Heart attack: Yes/No

- **If yes:**
 - **Have you experienced a heart attack in the last couple of years?**
 - **Does your history of heart attack interfere with your ability to wear an N95 mask or another respirator?**

b. Stroke: Yes/No

- **If yes:**
 - **Have you experienced a stroke in the last couple of years?**
 - **Does your history of stroke interfere with your ability to wear an N95 mask or another respirator?**

c. Angina: Yes/No

- **If yes:**
 - **Have you experienced angina in the last couple of years?**
 - **Does your history of angina interfere with your ability to wear an N95 mask or another respirator?**

d. Heart failure: Yes/No

- **If yes:**
 - **Have you experienced frequent exacerbation of your heart failure in the last couple of years?**
 - **Does heart failure interfere with your ability to wear an N95 mask or another respirator?**

e. Swelling in your legs or feet (not caused by walking): Yes/No

- **If yes:**
 - **Is this an issue that has not yet been medically evaluated?**
 - **Does it interfere with your ability to wear an N95 mask or another respirator?**

f. Heart arrhythmia (heart beating irregularly): Yes/No

- **If yes:**
 - **Is this an issue that has not yet been medically evaluated?**
 - **Does it interfere with your ability to wear an N95 mask or another respirator?**

g. High blood pressure: Yes/No

- **If yes, it is uncontrolled?**

h. Any other heart problem that you've been told about: Yes/No

- **If yes, Is the heart problem current and/or are you currently receiving healthcare for it?**
 - **If yes, does it interfere with your ability to wear an N95 mask or another respirator?**

6. Have you *ever had* any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest: Yes/No

- **If yes:**
 - **Is this an issue that has not yet been medically evaluated?**
 - **Does it interfere with your ability to wear an N95 mask or another respirator?**

b. Pain or tightness in your chest during physical activity: Yes/No

- **If yes:**
 - **Is this an issue that has not yet been medically evaluated?**
 - **Does it interfere with your ability to wear an N95 mask or another respirator?**

c. Pain or tightness in your chest that interferes with your job: Yes/No

d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No

- **If yes:**
 - **Is this an issue that has not yet been medically evaluated?**
 - **Does it interfere with your ability to wear an N95 mask or another respirator?**

e. Heartburn or indigestion that is **not related to eating**: Yes/No

- **If yes:**
 - **Is this an issue that has not yet been medically evaluated?**
 - **Does it interfere with your ability to wear an N95 mask or another respirator?**

f. Any other symptoms that you think may be related to heart or circulation problems: Yes/No

- **If yes, is the symptom(s) current and/or are you currently receiving healthcare for it?**
 - **If yes, does it interfere with your ability to wear an N95 mask or another respirator?**

7. Do you currently take medication for any of the following problems?

a. Breathing or lung problems: Yes/No

- **If yes:**
 - **Are your breathing or lung problems still uncontrolled while on medication?**
 - **Does it interfere with your ability to wear an N95 mask or another respirator?**

b. Heart trouble: Yes/No

- **If yes:**
 - **Is your heart trouble still uncontrolled while on medication?**
 - **Does it interfere with your ability to wear an N95 mask or another respirator?**

c. Blood pressure: Yes/No

- **If yes, is your blood pressure still uncontrolled while on medication?**

d. Seizures: Yes/No

- **If yes, are you still experiencing seizures while on medication?**

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:)

a. Eye irritation: Yes/No

- **If yes, has this issue been mitigated by your own facility or provider?**

b. Skin allergies or rashes: Yes/No

- **If yes, has this issue been mitigated by your own facility or provider?**

c. Anxiety: Yes/No

- **If yes, has this issue been mitigated by your own facility or provider?**

d. General weakness or fatigue: Yes/No

- **If yes, has this issue been mitigated by your own facility or provider?**

e. Any other problem that interferes with your use of a respirator: Yes/No

- **If yes, has this issue been mitigated by your own facility or provider?**

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

- **If yes, do you want to talk to another health care professional like your primary care provider before proceeding with fit testing?**

TO BE COMPLETED BY THE LICENSED HEALTHCARE PROFESSIONAL AFTER THE REVIEW:

Please select one of the following assessment and recommendation:

- No concern identified related to respirator use. Proceed with N-95 fit testing.
- Some responses need additional evaluation. Refer to another healthcare professional for approval of N-95 fit testing.
- N-95 fit testing cannot be performed. Alternative methods/ work accommodations will be needed for respiratory protection.

Employee has been provided a copy of this page which includes my recommendation.

Licensed Health Care Professional Signature

Date