OSHA Respirator Medical Evaluation Questionnaire

The following information must be provided by every student who has been selected to use any type of respirator.

1. **Today's Date:** Click or tap here to enter text.

2. **Your full name:** Click or tap here to enter text.

3. **Your age (to nearest year):** Click or tap here to enter text.

4. **Sex:** Male ☐ Female ☐

5. **Your height (ft./in.):** Click or tap here to enter text.

6. **Your weight (lbs.):** Click or tap here to enter text.

7. **Your Nursing School and year:** Click or tap here to enter text.

8. **Have you worn a respirator?**

   Yes ☐

   No ☐

9. **If you answered "yes," to question number 8, please explain what type(s):**

   Click or tap here to enter text.

10. **Do you currently smoke tobacco, or have you smoked tobacco in the last month:**

    Yes ☐

    No ☐

11. **Have you ever had any of the following conditions? Check only those you would answer "yes" to:**

Seizures ☐

Diabetes (sugar disease) ☐

Allergic reactions that interfere with your breathing ☐

Claustrophobia (fear of closed-in places) ☐

Trouble smelling odors ☐

12. **Have you ever had any of the following pulmonary or lung problems? Check only those you would answer "yes" to:**

Asbestosis ☐

Asthma ☐

Chronic bronchitis ☐

Emphysema ☐

Pneumonia ☐

Tuberculosis ☐

Silicosis ☐

Pneumothorax (collapsed lung) ☐

Lung cancer ☐

Broken ribs ☐

Any chest injuries or surgeries ☐

Any other lung problem that you've been told about ☐

13. **Do you currently have any of the following symptoms of pulmonary or lung illness? Check only those you would answer "yes" to:**

Shortness of breath ☐

Shortness of breath when walking fast on level ground or walking up a slight hill or incline ☐

Shortness of breath when walking with other people at an ordinary pace on level ground ☐

Have to stop for breath when walking at your own pace on level ground ☐

Shortness of breath when washing or dressing yourself ☐

(13. continued)

Shortness of breath that interferes with your job ☐

Coughing that produces phlegm (thick sputum) ☐

Coughing that wakes you early in the morning ☐

Coughing that occurs mostly when you are lying down ☐

Coughing up blood in the last month ☐

Wheezing ☐

Wheezing that interferes with your job ☐

Chest pain when you breathe deeply ☐

Any other symptoms that you think may be related to lung problems ☐

14. Have you ever had any of the following cardiovascular or heart problems? Check only those you would answer "yes" to:

Heart attack ☐

Stroke ☐

Angina ☐

Heart failure ☐

Swelling in your legs or feet (not caused by walking) ☐

Heart arrhythmia (heart beating irregularly) ☐

High blood pressure ☐

Any other heart problem that you've been told about ☐

15. Have you ever had any of the following cardiovascular or heart symptoms? Check only those you would answer "yes" to:

Frequent pain or tightness in your chest ☐

Pain or tightness in your chest during physical activity with your job ☐

In the past two years, have you noticed your heart skipping or missing a beat ☐

Heartburn or indigestion that is not related to eating ☐

Any other symptoms that you think may be related to heart or circulation problems ☐

16. **Do you currently take medication for any of the following problems? Check only those you would answer "yes" to:**

Breathing or lung problems ☐

Heart trouble ☐

Blood pressure ☐

Seizures ☐

17. **If you've used a respirator, have you ever had any of the following problems? Check only those you would answer "yes" to: (If you've never used a respirator, check NA)**

NA ☐

Eye irritation ☐

Skin allergies or rashes ☐

Anxiety ☐

General weakness or fatigue ☐

Any other problem that interferes with your use of a respirator ☐

18. **Have you ever lost vision in either eye (temporarily or permanently):**

Yes ☐

No ☐

19. **Do you currently have any of the following vision problems? Check only those you would answer "yes" to:**

Wear contact lenses ☐

Wear glasses ☐

Color blind ☐

Any other eye or vision problem ☐

20. **Have you ever had an injury to your ears, including a broken ear drum:**

Yes ☐

No ☐

21. **Do you currently have any of the following hearing problems? Check only those you would answer "yes" to:**

    Difficulty hearing ☐

    Wear a hearing aid ☐

    Any other hearing or ear problem ☐

22. **Have you ever had a back injury?**

    Yes ☐

    No ☐

23. **Do you currently have any of the following musculoskeletal problems? Check only those you would answer "yes" to:**

    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 ☐

    Climbing a flight of stairs or a ladder carrying more than 25 lbs ☐

    Any other muscle or skeletal problem that interferes with using a respirator ☐

24. **By checking the box, you acknowledge that you have reviewed this questionnaire with your Health Care Provider, prior to the start of clinical.** ☐