STATE UNIVERSITY OF NEW YORK
STONY BROOK
UNIVERSITY HOSPITAL
STONY BROOK, NEW YORK 11794

OSHA RESPIRATOR
MEDICAL EVALUATION QUESTIONNAIRE
(Mandatory)

Section 1:
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 area code): _________________________
9) The best time to phone you at this number : ____________________
10) Has your employer told you how to contact the health care profession 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-facepiece type, powered-air purifying, supplied air, self-contained breathing apparatus).
12) Have you worn a respirator (circle one): Yes / No

Section 2:
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"). A follow-up medical evaluation is necessary for an employee who gives a positive response to any question among questions 1 through 8.

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 (fits): Yes / No
    b. Diabetes (sugar disease): Yes / No
    c. Allergic reactions that interfere with your breathing: Yes / No
    d. Claustrophobia (fear of closed-in spaces): Yes / No
    e. Trouble smelling odors: Yes / No
3) Have you ever had any of the following pulmonary or lung problems?
    a. Asbestosis: Yes / No
    b. Asthma: Yes / No
    c. Chronic bronchitis: Yes / No
    d. Emphysema: Yes / No
    e. Pneumonia: Yes / No

f. Tuberculosis: Yes / No
g. Silicosis: Yes / No
h. Pneumothorax (collapsed lung): Yes / No
i. Lung cancer: Yes / No
j. Broken ribs: Yes / No
k. Any chest injuries or surgeries: Yes / No
l. Any other lung problem that you've been told about: Yes / No

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

a. Shortness of breath: Yes / No
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes / No
c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes / No
d. Have to stop for breath when walking at your own pace on level ground: Yes / No
e. Shortness of breath when washing or dressing yourself: Yes / No
f. Shortness of breath that interferes with your job: Yes / No
g. Coughing that produces phlegm (thick sputum): Yes / No
h. Coughing that wakes you early in the morning: Yes / No
i. Coughing that occurs mostly when you are lying down: Yes / No
j. Coughing up blood in the last month: Yes / No
k. Wheezing: Yes / No
l. Wheezing that interferes with your job: Yes / No
m. Chest pain when you breathe deeply: Yes / No
n. Any other symptoms that you think may be related to lung problems: Yes / No

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

a. Heart attack: Yes / No
b. Stroke: Yes / No
c. Angina: Yes / No
d. Heart failure: Yes / No
e. Swelling in your legs or feet (not caused by walking): Yes / No
f. Heart arrhythmia (heart beating irregularly): Yes / No
g. High blood pressure: Yes / No
h. Any other heart problem that you've been told about: Yes / No

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

a. Frequent pain or tightness in your chest: Yes / No
b. Pain or tightness in your chest during physical activity: Yes / No
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
e. Heartburn or indigestion that is not related to eating: Yes / No
f. Any other symptoms that you think may be related to heart or circulation problems: Yes / No

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

a. Breathing or lung problems: Yes / No

b. Heart trouble: Yes / No

c. Blood pressure: Yes / No

d. Seizures (fits): Yes / No

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

b. Skin allergies or rashes: Yes / No

c. Anxiety: Yes / No

d. General weakness or fatigue: Yes / No

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

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

MEDICAL CLEARANCE

After review of medical history and physical examination, I find the above named to be:

____ Fit for respirator use with no restrictions

____ Fit for respirator use with mild restrictions

____ Additional testing needed before fitness can be determined

____ Not fit for respirator use

Comments: ____

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______________________________________ ______________

Signature of Examining Physician Date

Office Address of Examining Physician ____

Telephone Number: ( ) ______________________