Medical Questionnaire for PAPR and N-95 Masks

Note to Evaluator: This questionnaire must be administered to employees in a way that ensures their understanding. Before asking the employee to fill out this questionnaire, please ask the following questions and record the employee’s response.

If the employee cannot read English, but understands and can speak English, or another evaluator who is not the employee’s supervisor may ask the questions and document the employee’s response. If the employee can neither read nor speak English, the evaluator must use an alternative method, suitable to the employee and the situation and document the method used. PLEASE PRINT LEGIBLY AND INCLUDE YOUR SS # AND/OR EMPLOYEE ID NUMBER.

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<th>Name:</th>
<th>Employee ID:</th>
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Question:

1. Have you had or do you have any of the following?
   a) Allergic reactions that interfere with breathing ................................................................. Yes No
   b) Trouble smelling odors ........................................................................................................... Yes No
   c) Seizures (fits) ............................................................................................................................ Yes No
   d) Diabetes (sugar disease) ........................................................................................................... Yes No
   e) Claustrophobia (fear of tight or enclosed spaces) ................................................................. Yes No

2. Have you ever had any of the following 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 (TB) ....................................................................................................................... Yes No
   g) Silicosis ...................................................................................................................................... Yes No
   h) Collapsed lung ........................................................................................................................... Yes No
   i) Lung cancer ............................................................................................................................... Yes No
   j) Broken ribs ................................................................................................................................. Yes No
   k) Chest injuries or surgeries ........................................................................................................ Yes No
   l) Any other lung problem ............................................................................................................. Yes No

3. Do you have any of the following symptoms?
   a) Shortness of breath .................................................................................................................... Yes No
   b) Shortness of breath when walking fast on level ground or up a slight incline or hill ........ Yes No
   c) Shortness of breath when walking with other people at a normal 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 ............................................................................................. Yes No
   h) Coughing that wakes you up early in the morning ............................................................... Yes No
   i) Coughing that occurs mostly when you are lying down .................................................... Yes No
   j) Coughing up blood (within 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

(over)
4. 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) Swelling in your legs or feet........................................... Yes  No
   e) Heart arrhythmia........................................................... Yes  No
   f) Any other heart problem ............................................... Yes  No

5. Have you 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) Heart skipping or missing a beat (within last two years) Yes  No
   e) Heartburn or indigestion that is not related to eating...... Yes  No
   f) Any other cardiovascular or circulatory problems........ Yes  No

6. Do you currently take any medication for the following?
   a) Breathing or lung problems............................................. Yes  No
   b) Heart trouble............................................................... Yes  No
   c) Blood pressure.............................................................. Yes  No
   d) Seizures (fits) ............................................................... Yes  No
   e) Any other cardiovascular or circulatory problems........ Yes  No

7. Do you currently smoke or have you smoked within the last month? Yes  No

8. Have you ever worn a respirator in the past? Yes  No

9. If so, have you ever had any of the following during respirator use?
   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 would interfere with respirator use Yes  No

10. Has your supervisor told you how to contact the safety officer (Sharon Berry) or health care provider who will review your evaluation Yes  No

11. Would you like to talk to the health care provider who will review your evaluation about your answers to the questions? Yes  No

Note: If the employee answered “Yes” to any part of questions 1-6 or 9, the evaluation must be reviewed by a licensed health care provider prior to granting approval for respirator use.

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<th>Evaluator Use Only</th>
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<td>□ Approved</td>
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| Evaluator signature: | Evaluator Name (printed): |

This medical evaluation has been developed in compliance with OSHA 1910.134, Appendix C.

Following a satisfactory fit testing for respirator use, the Health Care Worker was issued: (check one)

- □ Tecnol Reg. N95 (KC Clark)  □ 3M N95 1860  □ Test Failed, PAPR letter
- □ Tecnol Small N95 (KC Clark) □ 3M N95 1860 Small given
- □ Unable to fit test due to beard or otherwise, PAPR letter given
- □ Other, specify size and brand

Please send the completed forms to Leslie Ehrmantraut at University Health Service, room 404A. (Fax 257-9814)