Place LHD LogoHere

**OSHA Respirator Medical Screening Questionnaire**

|  |  |  |  |
| --- | --- | --- | --- |
| NAME | DOB | AGE | DATE |

GENDER: Male 🞎 Female 🞎

|  |  |  |
| --- | --- | --- |
| HEIGHT |  | WEIGHT |

YOUR JOB TITLE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(where you can be reached by the health care professional who reviews this questionnaire)*

HAVE YOU EVER WORN A RESPIRATOR? Yes 🞎 No 🞎

If yes, what types? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(ex. disposable respirator, full-face piece type, powered-air purifying, SCBA)*

|  |  |
| --- | --- |
| MANDATORY QUESTIONS   |  | | --- | | (ALL QUESTIONS IN THIS SECTION MUST BE COMPLETED BY EMPLOYEE  AND REVIEWERD BY A CLINICIAN PRIOR TO MEDICAL CLEARANCE) | |

Please check the appropriate box for each question

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Have you ever had any of the following conditions? | | | | |  | | |
| Seizures | Yes 🞎 No 🞎 | | | | |
| Diabetes | Yes 🞎 No 🞎 | | | | |
| Allergic reactions that interfere with your breathing | Yes 🞎 No 🞎 | | | | |
| Claustrophobia (fear of closed-in places) | Yes 🞎 No 🞎 | | | | |
| Trouble tasting/smelling odors | Yes 🞎 No 🞎 | | | | |
| 1. Have you ever had any of the following pulmonary or lung problems? | | | | |  | | |
| Asbestosis | Yes 🞎 No 🞎 | | | | |
| Asthma | Yes 🞎 No 🞎 | | | | |
| Chronic bronchitis | Yes 🞎 No 🞎 | | | | |
| Claustrophobia (fear of closed-in places) | Yes 🞎 No 🞎 | | | | |
| Emphysema | Yes 🞎 No 🞎 | | | | |
| Pneumonia | Yes 🞎 No 🞎 | | | | |
| Tuberculosis | Yes 🞎 No 🞎 | | | | |
| Silicosis  Pneumothorax (collapsed lung)  Lung cancer  Broken ribs  Any chest injuries or surgeries  Any other lung problem that you’ve been told about  Comments: | Yes 🞎 No 🞎  Yes 🞎 No 🞎  Yes 🞎 No 🞎  Yes 🞎 No 🞎  Yes 🞎 No 🞎  Yes 🞎 No 🞎 | | | | |
| 1. Do you currently smoke tobacco, or have you smoked tobacco in the last month | Yes 🞎 No 🞎 | | | | |
| 1. Do you currently have any of the following symptoms of pulmonary or lung illness? | | |  |
| Shortness of breath | | Yes 🞎 No 🞎 | | | | |
| Shortness of breath when walking fast on level ground or walking up a slight hill or incline | | Yes 🞎 No 🞎 | | | | |
| Shortness of breath when walking with other people at an ordinary pace on level ground | | Yes 🞎 No 🞎 | | | | |
| Have to stop for breath when walking at your own pace on level ground | | Yes 🞎 No 🞎 | | | | |
| Shortness of breath when washing or dressing yourself | | Yes 🞎 No 🞎 | | | | |
| Shortness of breath that interferes with your job | | Yes 🞎 No 🞎 | | | | |
| Coughing that produces phlegm (thick sputum) | | Yes 🞎 No 🞎 | | | | |
| 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 (*please explain*): | | Yes 🞎 No 🞎  Yes 🞎 No 🞎  Yes 🞎 No 🞎  Yes 🞎 No 🞎  Yes 🞎 No 🞎  Yes 🞎 No 🞎  Yes 🞎 No 🞎 | | | | |
| 1. Have you ever had any of the following cardiovascular or heart problems? | | |
| Heart attack | | Yes 🞎 No 🞎 | | | | |
| Stroke | | Yes 🞎 No 🞎 | | | | |
| Angina (chest pain) | | Yes 🞎 No 🞎 | | | | |
| Heart Failure | | Yes 🞎 No 🞎 | | | | |
| Swelling in your legs or feet (not caused by walking) | | Yes 🞎 No 🞎 | | | | |
| Heart arrhythmia (heart beating irregularly) | | Yes 🞎 No 🞎 | | | | |
| High blood pressure | | Yes 🞎 No 🞎 | | | | |
| Coughing that wakes you early in the morning  Any other heart problem that you've been told about (*please explain):* | | Yes 🞎 No 🞎 | | | | |
| 1. Have you ever had any of the following cardiovascular or heart symptoms? | | |  |
| Frequent pain or tightness in your chest | | Yes 🞎 No 🞎 | | | | |
| Pain or tightness in your chest during physical activity | | Yes 🞎 No 🞎 | | | | |
| Pain or tightness in your chest that interferes with your job | | Yes 🞎 No 🞎 | | | | |
| In the past two years, have you noticed your heart skipping or missing a beat | | Yes 🞎 No 🞎 | | | | |
| Heartburn or indigestion that is not related to eating | | Yes 🞎 No 🞎 | | | | |
| Any other symptoms that you think may be related to heart or circulation problems (*please explain :)* | | Yes 🞎 No 🞎 | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Do you currently take medication for any of the following problems? | | |  |
| Breathing or lung problems | Yes 🞎 No 🞎 |
| Heart trouble | Yes 🞎 No 🞎 |
| Blood pressure | Yes 🞎 No 🞎 |
| Seizures | Yes 🞎 No 🞎 |
| Any other medications that may interfere with your use of a respirator (*please explain*): |  |

1. If you've used a respirator, have you *ever had* any of the following problems?

If you've never used a respirator, check this box and proceed to question 9 🞎

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Eye irritation | Yes 🞎 No 🞎 |
| Skin allergies or rash | Yes 🞎 No 🞎 |
| Anxiety | Yes 🞎 No 🞎 |
| General weakness or fatigue | Yes 🞎 No 🞎 |
| Any other problem that interferes with your use of a respirator (*please explain*): | Yes 🞎 No 🞎 |

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

**EMPLOYEE SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*This concludes the Employee portion of the questionnaire. Thank you for your time.*

MEDICAL CLEARANCE

This portion must be completed by a designated clinician before employee can proceed with fit testing.

**CLINICIAN NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 I have reviewed the medical questionnaire with the employee

🞎 I have reviewed the medical questionnaire without the employee

*Based upon my findings, I recommend that:*

|  |  |  |
| --- | --- | --- |
| 🞎 **The employee proceeds with fit testing and *does not* require presence of a clinician** | 🞎 **The employee proceeds with fit testing with the presence of a clinician** | 🞎 **Further physical examination by a physician be performed in order to determine if employee is medically suited for fit testing** |

**CLINICIAN SIGNATURE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHPS-R003**

**7/1/2025**