Occupational Health Department
111 Michigan Ave N.W.
Washington, DC 20010-2970
(202) 476-2035 Email: oh@childrensnational.org

OH Staff: Please Circle One
DECON TEAM
N95
Other

Respirator Medical Questionnaire

The following information must be provided by every employee who has been selected to use any type of respirator (Print).

NAME:_____ DATE:_____ AGE:_____
Male /Female (circle one) ID #_____ Height_____ Weight_____
Job Title:_____ Department_____
If contractor….Agency name and POC_____
Type of Respirator you will use? (Please circle) N95 Supplied Air (SAR) PAPR OTHER
Have you worn a respirator, if yes what type? Any difficulties with use? Describe:_____
Will you be wearing any other personal protective equipment that might touch or interfere with the respirator (Such as headband, splash shield etc)? _____
THE QUESTIONS BELOW MUST BE ANSWERED BY EVERY EMPLOYEE WHO USES ANY TYPE OF RESPIRATOR (PLEASE PRINT LEGIBLY)

DO YOU NOW OR HAVE YOU EVER SMOKED*?* (Please circle) Yes or No, If yes, for how many years?_____

HAVE YOU EVER HAD THE FOLLOWING CONDITIONS? (Please circle, if yes, explain below)

Seizures, diabetes, allergic reactions that interfere with breathing, claustrophobia, trouble smelling odors?
_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING PULMONARY OR LUNG PROBLEMS? (Please circle, if yes, explain below)

Asbestosis, asthma, chronic bronchitis, emphysema, pneumonia, tuberculosis, silicosis, collapsed lung, lung cancer, broken ribs, any chest injuries or surgeries, any other lung problem that you have been told about?
_____
DO YOU *CURRENTLY* HAVE ANY OF THE FOLLOWING SYMPTOMS OF PULMONARY OR LUNG ILLNESS? (Please circle, if yes explain)

Shortness of breath (SOB), SOB when walking fast on ground level/incline, SOB when walking at ordinary pace level ground?
Have to stop when walking at ordinary pace or level ground, SOB that interferes with washing/dressing yourself, SOB that interferes with your job, coughing that produces phlegm, coughing that wakes you early in the morning, coughing that occurs when 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 related to lung problems?
_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING CARDIOVASCULAR OR HEART PROBLEMS (Please circle, if yes and explain)

Heart attack, stroke, angina, heart failure, swelling in your feet (not caused by walking), heart arrhythmia, high blood pressure, and any other heart problem you are aware of?
_____
DO YOU CURRENTLY TAKE MEDICATIONS FOR ANY OF THE FOLLOWING PROBLEMS? (Please circle, if yes explain)

Breathing or lung problems, heart trouble, blood pressure, seizures_____

IF YOU'VE USED A RESPIRATOR HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS? IF YOU HAVE NOT **(SKIP SECTION)**
Please Circle:
Eye irritation Yes or No Skin allergies or rashes Yes or No Anxiety Yes or No
General weakness or fatigue Yes or No
Any other problems that interferes with using a respirator Yes or No

Please Circle: Would you like to talk to a heath care professional who will review the answers to the questionnaire? Yes or No
Have you been previously fit tested?_____ If yes, what size_____
Do you have a latex allergy Yes or No

Employee's Signature:_____Today's Date:_____

FOR EXAMINERS USE ONLY:
Is there documentation of previous medical screening for respirator use? If yes date_____
Are there any changes from last screening?_____
Approved:_____Approved with restrictions:_____ Denied:_____ Size:_____
3MN95: 1860S_____; 1860_____; 1870_____; PAPAR_____; SAR_____; Other_____

Clinician Signature:_____Today's Date:_____