OSHA Respirator Medical Evaluation

PROJECT TITLE

BMC MEDICAL STAFF MEMBER

Last Name | First Name | ID # | Date

Age | Date of Birth | ☐ Male ☐ Female Gender | Height

Weight (lbs) | Job Title | Department | Phone Number

TYPE OF RESPIRATOR

You can check more than one category

☐ **N95** (most common of the seven types of particulate filtering facepiece respirators). Filters at least 95% of airborne particles .3 mcg or later, but is not resistant to oil.

☐ **PAPR** (powered air purifying respirator), used if unable to use N95, e.g. facial hair interfering with fit, facial shape not allowing tight fit, or if need positive pressure respirator.

☐ **Other:** full face or SCBA (self contained breathing apparatus), please utilize full OSHA Respirator Questionnaire with Part A and B.

Have you worn a respirator? ☐ Yes ☐ No

If yes, what types?

MEDICAL HISTORY

Please check yes or no for each answer

☐ Yes ☐ No **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? If no, check box and go to #3.**

- ☐ Yes ☐ No Seizures (fits)
- ☐ Yes ☐ No Diabetes (sugar disease)
- ☐ Yes ☐ No Allergic reactions that interfere w/your breathing
- ☐ Yes ☐ No Claustrophobia (fear of closed-in places)
- ☐ Yes ☐ No Trouble smelling odors

☐ Yes ☐ No **3. Have you ever had any of the following pulmonary or lung problems? If no, check box and go to #4.**

- ☐ Yes ☐ No Asbestosis
- ☐ Yes ☐ No Asthma
- ☐ Yes ☐ No Chronic Bronchitis
- ☐ Yes ☐ No Emphysema
- ☐ Yes ☐ No Pneumonia
- ☐ Yes ☐ No Tuberculosis
- ☐ Yes ☐ No Silicosis
- ☐ Yes ☐ No Pneumothorax (collapsed lung)
- ☐ Yes ☐ No Lung cancer
- ☐ Yes ☐ No Broken ribs
- ☐ Yes ☐ No An chest injuries or surgeries
- ☐ Yes ☐ No Any other lung problem you've been told about

☐ Yes ☐ No **4. Do you currently have any of the following symptoms of pulmonary or lung illness? If none, check box and go to #5.**

- ☐ Yes ☐ No Shortness of breath
- ☐ Yes ☐ No when walking fast on level ground or walking up a slight hill or incline
- ☐ Yes ☐ No 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
- ☐ Yes ☐ No that interferes with your job
- ☐ Yes ☐ No Coughing that produces phlegm
- ☐ Yes ☐ No that wakes you early in the morning
- ☐ Yes ☐ No that occurs mostly when lying down
- ☐ Yes ☐ No Coughing up blood in the last month
- ☐ Yes ☐ No Wheezing
- ☐ Yes ☐ No that interferes with your job
- ☐ Yes ☐ No Chest pain when you breathe deeply
- ☐ Yes ☐ No Any other symptoms you think may be related to lung problems

MEDICAL HISTORY CONTINUED

☐ Yes ☐ No **5. Have you ever had any of the following cardiovascular or heart problems? If no, check box and go to #6.**

☐ Yes ☐ No Heart attack

☐ Yes ☐ No Stroke

☐ Yes ☐ No Angina

☐ Yes ☐ No Heart failure

☐ Yes ☐ No Swelling in your legs or feet (not caused by walking)

☐ Yes ☐ No High blood pressure

☐ Yes ☐ No Any other heart problem you've been told about

☐ Yes ☐ No **6. Have you ever had any of the following cardiovascular or heart symptoms? If no, check box and go to #7.**

☐ Yes ☐ No Frequent pain or tightness in your chest

☐ Yes ☐ No Pain or tightness in your chest during physical activity

☐ Yes ☐ No that interferes with your job

☐ Yes ☐ No In the past two years, have you noticed your hear skipping or missing a beat?

☐ Yes ☐ No Heartburn or indigestion not related to eating

☐ Yes ☐ No Any other symptoms you think might be related to heart or circulation problems

☐ Yes ☐ No **7. Do you currently take medication for any of the following problems? If no, check box and go to #8.**

☐ Yes ☐ No Breathing or lung problems

☐ Yes ☐ No Heart trouble

☐ Yes ☐ No Blood pressure

☐ Yes ☐ No 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 box and go to question #9.**

☐ Yes ☐ No Eye irritation

☐ Yes ☐ No Skin allergies or rashes

☐ Yes ☐ No General weakness or fatigue

☐ Yes ☐ No 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?**

You may contact the BMC Occupational and Environmental Health Service 617-638-8400 to discuss any concerns with the OEM clinician who will review this questionnaire.

FIT TESTING | PI/PD SIGNATURES

Fit testing must be performed initially and repeated for each different brand of mask used (BMC is currently using 3M 1860 or 1860S, wt changes of 10 lbs, changes in facial shape (i.e. surgery, injury, dental procedure), any issue causing mask to not fit tightly, and periodically thereafter.

To maintain your confidentiality, your supervisor must not look at or review your answers and must tell you how to deliver or send this questionnaire to the health care professional who will review it. Questionnaires will go to your BMC Occupational Health and Environmental Medicine Department employee health record; only OEM NPs or MDs will review your questionnaire -- access will be restricted per regulatory guidance.

BY SIGNING THIS DOCUMENT, I certify ...

Name (printed)

Date

Signature / Electronic Signature