OSHA Respirator Medical Evaluation Questionnaire
Section 1910.134, Appendix C (Mandatory)

Today's date: __________________ Name: ___________________ College: ____________________________
Height: ______ ft. ______ in. Weight: _____ lbs. Birthdate: _______________ Age (to nearest year): ________ Sex (circle one): Male / Female

Phone number where you can be reached by the health care professional who reviews this questionnaire (include Area Code): ____________________________
The best time to phone you at this number: ____________________________
Has your college told you how to contact the health care professional who will review this questionnaire? (circle one): Yes / No

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).

Have you worn a respirator? (circle one): Yes / No If "yes," what type(s): ____________________________

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?
2. Have you ever had any of the following conditions?
  a. Seizures (fits)
  b. Diabetes (sugar disease)
  c. Allergic reactions that interfere with your breathing
  d. Claustrophobia (fear of closed-in places)
  e. Trouble smelling odors
3. Have you ever had any of the following pulmonary or lung problems?
  a. Asbestosis
  b. Asthma
  c. Chronic bronchitis
  d. Emphysema
  e. Pneumonia
  f. Tuberculosis
  g. Silicosis
  h. Pneumothorax (collapsed lung)
  i. Lung cancer
  j. Broken ribs
  k. Any chest injuries or surgeries
  l. Any other lung problem that you've been told about
4. Do you currently have any of the following symptoms of pulmonary or lung illness?
  a. Shortness of breath
  b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
  c. Shortness of breath when walking with other people at an ordinary pace on level ground
  d. Have to stop for breath when walking at your own pace on level ground
  e. Shortness of breath when washing or dressing yourself
  f. Shortness of breath that interferes with your job
  g. Coughing that produces phlegm (thick sputum)
  h. Coughing that wakes you early in the morning
  i. Coughing that occurs mostly when you are lying down
  j. Coughing up blood in the last month
  k. Wheezing
  l. Wheezing that interferes with your job
  m. Chest pain when you breathe deeply

By answering "Yes" to any questions, I am to contact Student Health Services (792-3664) and schedule a follow-up evaluation appointment.

I certify the above information is correct: ____________________________________________

**SHS PERSONNEL PLEASE COMPLETE THIS SECTION**

Mask Fit Test  □ Approved  □ Denied  Signature: ___________________________________ Date: ________________

□ Copy given, date: ____________________________

(Other relevant information or notes can be added here.)