OSHA/UAMS-N95 and PAPR/CAPR Respirator Medical Evaluation Questionnaire
(Includes the mandatory questions on form from OSHA Appendix C to Sec. 1910.134)

SUPERVISOR'S STATEMENT: Respirator Requirement

EMPLOYEE NAME (Print) _____Phone Number_____

Department _____Unit_____ Job title_____

Supervisor's Name (Print) _____Date_____

To the employee:

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. Your supervisor is not to review your answers. **Send completed questionnaire to the Employee Health Services by emailing StudentAndEmployeeHealth@uams.edu or at slot #530-8 or fax 296-1230.**

Part A. Section 1. (**Mandatory**) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date: _____
2. SAP Number or Social Security Number : _____
3. Date of Birth: _____
4. Sex (mark one): ☐Male ☐Female
5. Your height: _____ ft. _____ in.
6. Your weight: _____ lbs.
7. Do you have a beard or mustache? ☐Yes ☐No
8. 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. ☐ Powered Air Purifying Respirator (PAPR/CAPR)

9. Have you worn a respirator before ☐Yes ☐No If yes, what type(s): _____
   Describe any difficulties with its use _____

Employee: Go to next page. DO NOT mark below this line

Final Statement to OHS

Employee ☐ does require respirator use medical clearance exam
☐ does not require respirator use medical clearance exam unless problems encountered with the fit testing.

Clearance ☐ is not given to wear the N-95 respirator
☐ is given to wear the N-95 respirator
Re-evaluation of employee should occur: _____

Reviewing Clinician (print) _____

Clinician signature _____ Date _____

OSHA Respirator Medical Questionnaire (pg 2) Name _____

Part A. Section 2a. (Mark "yes" or "no").

1. Do you have asthma?……..……. ☐Yes ☐No
2. If yes, is it controlled on medication?..... ☐Yes ☐No
3. Do you have high blood pressure? ..... ☐Yes ☐No
4. If yes, is it controlled on medication?..... ☐Yes ☐No
5. Do you have heart disease? ..... ☐Yes ☐No
6. If yes, does it decrease you ability to exercise or to work? ..... ☐Yes ☐No
7. Do you have chronic lung disease? ..... ☐Yes ☐No
8. If yes, does it decrease you ability to exercise or to work?..... ☐Yes ☐No
9. Do you have seizures?..... ☐Yes ☐No
10. If yes, when was your last attack? _____

Part A. Section 2b. (Mark "yes" or "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?
   a. Seizures (fits): ……. ☐Yes ☐No
   b. Diabetes (sugar disease): …… ☐Yes ☐No
   c. Allergic reactions that interfere with your breathing: …… ☐Yes ☐No
   d. Claustrophobia (fear of closed-in places): ……. ☐Yes ☐No
   e. Trouble smelling odors: ……. ☐Yes ☐No
3. Have you ever had any of the following pulmonary or 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: …….. ☐Yes ☐No
   g. Silicosis: ……. ☐Yes ☐No
   h. Pneumothorax (collapsed lung): …… ☐Yes ☐No
   i. Lung cancer: ……... ☐Yes ☐No
   j. Broken ribs: …… ☐Yes ☐No
   k. Any chest injuries or surgeries: ……. ☐Yes ☐No
   l. Any other lung problem that you've been told about: …… ☐Yes ☐No
4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath: …… ☐Yes ☐No
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: …….. ☐Yes ☐No
   c. Shortness of breath when walking with other people at an ordinary 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

4. Continued—symptoms of pulmonary or lung illness?
   f. Shortness of breath that interferes with your job: …….. ☐Yes ☐No
   g. Coughing that produces phlegm (thick sputum): …….. ☐Yes ☐No
   h. Coughing that wakes you early in the morning: ……... ☐Yes ☐No
   i. Coughing that occurs mostly when you are lying down: ……... ☐Yes ☐No
   j. Coughing up blood in 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
5. 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. Heart failure: …….. ☐Yes ☐No
   e. Swelling in your legs or feet (not caused by walking): ……. ☐Yes ☐No
   f. Heart arrhythmia (heart beating irregularly): ……. ☐Yes ☐No
   g. High blood pressure: …….. ☐Yes ☐No
   h. Any other heart problem that you've been told about: ……... ☐Yes ☐No
6. Have you ever 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. In the past two years, have you noticed your heart skipping or missing a beat:
      …… ☐Yes ☐No
   e. Heartburn or indigestion that is not related to eating: ……... ☐Yes ☐No
   f. Any other symptoms that you think may be related to heart or circulation problems:
      ……. ☐Yes ☐No
      (if "yes", please list)_____
7. Do you currently take medication for any of the following problems?
   a. Breathing or lung problems: …….. ☐Yes ☐No
   b. Heart trouble: ……. ☐Yes ☐No
   c. Blood pressure: …….. ☐Yes ☐No
   d. Seizures (fits): …… ☐Yes ☐No
   Please list the medication_____
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 space ☐ and go to question 9:)
   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 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: …….. ☐Yes ☐No