# UNIVERSITY OF MIAMI

# Employee Health Office

RESPIRATOR MEDICAL EVALUATION QUESTIONAIRE FOR N95 USERS

**After completion, please email to** [**UMHealthOffice@miami.edu**](mailto:UMHealthOffice@miami.edu)

Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination. Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Employee ID (C#)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Department Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Supervisor Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Your age (to nearest year):\_\_\_\_\_\_ 2. Check one  **Male  ¨Female** 3. Your Height: \_\_\_\_ ft. \_\_\_\_ in. 4. Weight (lbs) \_\_\_\_\_ |

14. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15. The best time to phone you at this number: \_\_\_\_\_\_\_\_\_\_\_\_

16. Has your employer told you how to contact the health care

professional who will review this questionnaire (check one)?

**Yes  No**   
  
17. 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).   
  
18. Have you worn a respirator before?  Yes  No  
  
If "Yes," what type(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part A. Section 2.** (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please check "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?

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| 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?

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| 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?

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | | **No** |
| 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. |  |  | |
| n.        Any other symptoms that you think  may be related to lung problems. |  |  | |

5. Have you ***ever had*** any of the following cardiovascular or heart problems?

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| a.        Heart attack |  |  |
| b.        Stroke |  |  |
| c.        Angina |  |  |
| d.        Heart failure |  |  |
| e.        Swelling in your legs or feet (not  caused by walking). |  |  |
| f.         Heart arrhythmia (heart beating  irregularly). |  |  |
| g.        High blood pressure. |  |  |
| h.        Any other heart problem that you've  been told about. |  |  |

6. Have you ***ever had*** any of the following cardiovascular or heart symptoms?

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| a.        Frequent pain or tightness in your  chest. |  |  |
| b.        Pain or tightness in your chest during  physical activity. |  |  |
| c.        Pain or tightness in your chest that  interferes with your job. |  |  |
| d.        In the past two years, have you noticed  your heart skipping or missing a beat. |  |  |
| e.        Heartburn or indigestion that is not  related to eating. |  |  |
| f.         Any other symptoms that you think  may be related to heart or circulation  problems. |  |  |

7. Do you ***currently*** take medication for any of the following problems?

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| a.        Breathing or lung problems |  |  |
| b.        Heart trouble |  |  |
| c.        Blood pressure |  |  |
| d.        Seizures (fits) |  |  |

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:)

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| a.        Eye irritation |  |  |
| b.        Skin allergies or rashes |  |  |
| c.        Anxiety |  |  |
| d.        General weakness or fatigue |  |  |
| e.        Any other problem that interferes with   your use of a respirator. |  |  |

9. 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/Type Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**

Appendix C to Sec. 1910.134: **OSHA Respirator Medical Evaluation Questionnaire (Mandatory)**