

Medical Questionnaire N-95 Disposable Respirator

Date: _____

Name: _____

SSN: _____

Work Phone: _____

Work Area: _____

Supervisor: _____

Job Title: _____

Age Male Female Height: ft. in. Weight lb.

Have you ever worn a respirator? **YES** **NO**

Do you currently smoke tobacco, or have you smoked tobacco in the last month?
..... **YES** **NO**

Have you ever had any of the following conditions?

- 1. Seizures (fits) **YES** **NO**
- 2. Diabetes (sugar disease)..... **YES** **NO**
- 3. Allergic reactions that interfere with your breathing..... **YES** **NO**
- 4. Claustrophobia **YES** **NO**
- 5. Trouble smelling odors **YES** **NO**

Have you ever had any of the following pulmonary or lung problems?

- 1. Asbestosis **YES** **NO**
- 2. Asthma **YES** **NO**
- 3. Chronic bronchitis..... **YES** **NO**
- 4. Emphysema..... **YES** **NO**
- 5. Pneumonia..... **YES** **NO**
- 6. Tuberculosis **YES** **NO**
- 7. Silicosis **YES** **NO**
- 8. Pneumothorax (collapsed lung) **YES** **NO**
- 9. Lung cancer..... **YES** **NO**
- 10. Broken ribs..... **YES** **NO**
- 11. Any chest injuries or surgeries..... **YES** **NO**
- 12. Any other lung problem that you've been told about **YES** **NO**

Do you currently have any of the following symptoms of pulmonary or lung illness?

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1.Shortness of breath..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.Shortness of breath when walking fast on level ground or up a slight hill or
incline..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.Shortness of breath when walking with other people at an ordinary pace on level
ground | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.Have to stop for breath when walking at your own pace on level ground..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5.Shortness of breath when washing or dressing yourself..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6.Shortness of breath that interferes with your job..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7.Coughing that produces phlegm (thick sputum)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8.Coughing that wakes you early in the morning | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.Coughing that occurs mostly when you are lying down..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10.Coughing up blood in the last month..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.Wheezing | <input type="checkbox"/> | <input type="checkbox"/> |
| 12.Wheezing that interferes with your job..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13.Chest pain when you breathe deeply | <input type="checkbox"/> | <input type="checkbox"/> |
| 14.Any other symptoms that you think may be related to lung problems | <input type="checkbox"/> | <input type="checkbox"/> |

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

- | | | |
|--|--------------------------|--------------------------|
| 1.Heart attack | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.Angina..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.Heart failure | <input type="checkbox"/> | <input type="checkbox"/> |
| 5.Swelling in your legs or feet (not caused by walking)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6.Heart arrhythmia (heart beating irregularly)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7.High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| 8.Any other heart problem that you've been told about | <input type="checkbox"/> | <input type="checkbox"/> |

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

- | | | |
|---|--------------------------|--------------------------|
| 1.Frequent pain or tightness in your chest | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.Pain or tightness in your chest during physical activity | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.Pain or tightness in your chest that interferes with your job..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.In the past two years, have you noticed your heart skipping or missing a
beat | <input type="checkbox"/> | <input type="checkbox"/> |
| 5.Heartburn or indigestion that is not related to eating..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6.Any other symptoms that you think may be related to heart or circulation
problems..... | <input type="checkbox"/> | <input type="checkbox"/> |

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

- | | | |
|------------------------------------|--------------------------|--------------------------|
| 1.Breathing or lung problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.Heart trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.Blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.Seizures (fits)..... | <input type="checkbox"/> | <input type="checkbox"/> |

If you've used a respirator, have you ever had any of the following problems?

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1.I have never used a respirator | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.Eye irritation | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.Skin allergies or rashes | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.Anxiety..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5.General weakness or fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| 6.Any other problem that interferes with your use of a respirator..... | <input type="checkbox"/> | <input type="checkbox"/> |

Would you like to talk to the health care professional who will review your answers on this questionnaire?

Health Care Professional Approval

Employee Signature