The Center for Health Wellness and Personal
Counseling Room HS100
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Submission link:
https://lf.bergen.edu/forms/hs0001

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

Part A. Section 1. The following information must be completed by every student who will be using any type of respirator. The physician signature/stamp is required for the completed questionnaire. (please print).

1. Today's date:_____ Bergen ID # _____

2. Your name:_____Program of Study_____

3. Date of Birth:_____ BCC email: _____

4. Sex: Male / Female

5. Height: _____ft. ____ in.

6. Weight: _____ lbs.

7. A phone number where you can be reached by Health Care Provider who reviews this questionnaire:
_____

8. What is the best time to reach you at this number? _____

9. Has your instructor told you how to contact the health care professional who will review this questionnaire?

Please Circle: Yes No

10. The type of respirator you will use:

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).

11. Have you worn a respirator?

Please Circle: Yes No

If so, what type?

Part A. Section 2. Questions 1 through 9 must be answered by every student who has been selected to use any type of respirator (please place a check mark in the `YES or NO column).

Question	Response	
	YES	**NO**
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:		
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?		
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?		
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?		
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 box and go to question 9).***		
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. Have you ever lost vision in either eye (temporarily or permanently)?		

VERIFICATION/CONSENT STATEMENT

I verify that the information I provided in this medical history is true and complete to the best of my knowledge. I understand that this evaluation is designed to satisfy regulatory requirements and should not be considered to be a routine medical examination. ***Further, I agree to "self-report" to my supervisor changes in my medical condition that might affect my ability to work safely in a respirator.***

_____

Full Name (Printed) Signature Date

Respirator Questionnaire Reviewed By Licensed Heatlh Care Provider:

_____

Physician Signature and Date

_____

Office Name and Address Stamp

- This candidate is cleared to wear this type of respirator
- Further examination required

Licensed Health Care Provider Review/Comments:

OSHA Mandatory Respirator Medical Evaluation Questionnaire (Standard Number: 1910.134 App C)