Student ID: _____

The Center for Health, Wellness & Personal Counseling Room HS100
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OSHA Respirator Medical Evaluation Questionnaire (Mandatory)
Appendix C to Sec. 1910.134

Part A. Section 1. All students who has been selected to use any type of respirator must provide the following information:(please print)

Today's date: _____BCC ID # _____Program _____
Print your name: _____ Date of Birth:_____
Height: _____ Weight: _____lbs.
Contact phone number : _____Email :_____

Have you worn a respirator in the past? Yes _____ No_____
If "yes", what type(s): _____ Physical exertion while wearing a respirator: Mild ____ Moderate _____Strenuous_____ Maximum time you wear a respirator in a single day?: _____hours
Do you exercise? Yes _____ No _____ If "yes" describe how often and what exercise activities are: _____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by "Yes" or "No"

1. **Do you currently smoke tobacco, or have you smoked tobacco in the last month?**
   a. Yes __No__
   b. If yes, how many packs per day? __1/2 or less __1 pack __2packs __2 or more
   c. How many years have you smoked? __1-9 yrs.__10-19 yrs.__ 20-29 yrs. __30 or more
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 problems 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 ____Yes____No
b. Shortness of breath when walking fast on level ground or walking up a slight ____Yes ____No Shortness of breath when walking with other people at an ordinary pace on level ground___Yes ____No
c. Have to stop for breath when walking at your own pace on level ground ____Yes ____No
d. Shortness of breath when washing or dressing yourself ____Yes ____No
e. Shortness of breath that interferes with your job ____Yes ____No
f. Coughing that produces phlegm (thick sputum) ____Yes ____No
g. Coughing that wakes you early in the morning ____Yes ____No
h. Coughing that occurs mostly when you are lying down ____Yes ____No
i. Coughing up blood in the last month ____Yes ____No
j. Wheezing ____Yes ____No
k. Wheezing that interferes with your job ____Yes ____No
l. Chest pain when you breathe deeply ____Yes ____No
m. Any other symptoms that you think may be related to lungs
_____

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
_____
i. Frequent pain or tightness in your chest _____Yes _____No
j. Pain or tightness in your chest during physical activity _____Yes _____No
k. Pain or tightness in your chest that interferes with your job _____Yes _____No
l. In the past two years, have you noticed your heart skipping or missing a beat _____Yes _____No
m. Heartburn or symptoms that is not related to eating _____Yes _____No
n. Any other symptoms that you may have that are related to heart or circulation problems
_____ .

6. **Do you currently take medications 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
7. **If you've used a respirator, have you ever had any of the following problems?**
    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
    _____
8. **Have you ever lost vision in either eye (temporarily or permanently)?**
    a. _____Yes _____No
9. **Do you currently have any of the following vision problems?**
    a. Wear glasses _____Yes _____No
    b. Wear contact lenses _____Yes _____No
    c. Color blind _____Yes _____No
    d. Any other eye or vision problem _____Yes _____No
10. **Have you ever had an injury to your ears, including a broken ear drum? _____Yes _____No**
11. **Do you currently have any of the following hearing problems?**
    a. Difficulty breathing _____Yes _____No
    b. Wearing a hearing aid _____Yes _____No
    c. Any other hearing or ear problem _____Yes _____No
12. **Have you ever had a back injury? _____Yes _____No**
13. **Do you currently have any of the following musculoskeletal problems?**
    Weakness in any of your arm, hands, legs or feet _____Yes _____No
    a. Back Pain _____Yes _____No
    b. Difficulty fully moving your arms and legs _____Yes _____No
    c. Pain or stiffness when you lean forward or backwards at the waist
    _____Yes _____No
    d. Difficulty fully moving your head up or down _____Yes _____No
    e. Difficulty fully moving your head side to side _____Yes _____No
    f. Difficulty bending at your knees _____Yes _____No
    g. Difficulty squatting to the ground _____Yes _____No
    h. Climbing a flight of stairs or a ladder carrying more than 25 lbs.
    _____Yes _____No

Any additional comments you would like to make: _____
_____

To the best of my knowledge, the information I have provided is true and accurate. Student

Signature: _____Date:_____

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