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?Yes __No__
If yes, how many packs per day? __1/2 or less __1 pack __2packs __2 or more
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?

Seizures (fits)	_____Yes _____No
Diabetes (sugar disease)	_____Yes _____No
Allergic reactions that interfere with your breathing	_____Yes ____No
Claustrophobia (fear of closed-in places)	_____Yes _____No
Trouble smelling odors	_____Yes _____No

Name: _____ BCC ID: _____

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

Asbestosis	**_____Yes _____No**
Asthma	_____Yes _____No
Chronic bronchitis	_____Yes _____No
Emphysema	_____Yes _____No
Pneumonia	_____Yes _____No
Tuberculosis	_____Yes _____No
Silicosis	_____Yes _____No
Pneumothorax (collapsed lung)	_____Yes _____No
Lung cancer	_____Yes _____No
Broken ribs	_____Yes _____No
Any chest injuries or surgeries	_____Yes _____No

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?

Shortness of breath	____Yes____No
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
Have to stop for breath when walking at your own pace on level ground	____Yes ____No
Shortness of breath when washing or dressing yourself	____Yes ____No
Shortness of breath that interferes with your job	____Yes ____No
Coughing that produces phlegm (thick sputum)	____Yes ____No
Coughing that wakes you early in the morning	____Yes ____No
Coughing that occurs mostly when you are lying down	____Yes ____No
Coughing up blood in the last month	____Yes ____No
Wheezing	____Yes ____No
Wheezing that interferes with your job	____Yes ____No
Chest pain when you breathe deeply	____Yes ____No

Any other symptoms that you think may be related to lungs _____

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

Heart attack	_____Yes _____No
Stroke	_____Yes _____No
Angina	_____Yes _____No
Heart Failure	_____Yes _____No
Swelling in your legs or feet (not caused by walking)	_____Yes _____No
Heart arrhythmia (heart beating irregularly)	_____Yes _____No
High blood pressure	_____Yes _____No

Any other heart problem that you've been told about _____

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

Frequent pain or tightness in your chest	_____Yes _____No
Pain or tightness in your chest during physical activity	_____Yes _____No
Pain or tightness in your chest that interferes with your job	_____Yes _____No
In the past two years, have you noticed your heart skipping or missing a beat	_____Yes _____No
Heartburn or symptoms that is not related to eating	_____Yes _____No

Any other symptoms that you may be related to heart or circulation problems _____

_____.

Name: _____ BCC ID: _____

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

Breathing or lung problems	_____Yes _____No
Heart trouble	_____Yes _____No
Blood Pressure	_____Yes _____No
Seizures (fits)	_____Yes _____No

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)

Eye irritation	_____Yes _____No
Skin allergies or rashes	_____Yes _____No
Anxiety	_____Yes _____No
General weakness or fatigue	_____Yes _____No

Any other problem that interferes with your use of a respirator _____

9. Have you ever lost vision in either eye (temporarily or permanently) _____Yes _____No

10. Do you currently have any of the following vision problems?

Wear glasses	_____Yes _____No
Wear contact lenses	_____Yes _____No
Color blind	_____Yes _____No
Any other eye or vision problem	_____Yes _____No

11. Have you ever had an injury to your ears, including a broken ear drum: _____Yes _____No

12. Do you currently have any of the following hearing problems?

Difficulty breathing	_____Yes _____No
Wearing a hearing aid	_____Yes _____No
Any other hearing or ear problem	_____Yes _____No

13. Have you ever had a back injury _____Yes _____No

14. Do you currently have any of the following musculoskeletal problems?

Weakness in any of your arm, hands, legs or feet	_____Yes _____No
Back Pain	_____Yes _____No
Difficulty fully moving your arms and legs	_____Yes _____No
Pain or stiffness when you lean forward or backwards at the waist	_____Yes _____No
Difficulty fully moving your head up or down	_____Yes _____No
Difficulty fully moving your head side to side	_____Yes _____No
Difficulty bending at your knees	_____Yes _____No
Difficulty squatting to the ground	_____Yes _____No
Climbing a flight of stairs or a ladder carrying more than 25 lbs.	_____Yes _____No

Name: _____ BCC ID: _____

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:_____