



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:		

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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:		

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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? <i>(If you've never used a respirator, check the following box and go to question 9).</i>		
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 Health 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: