

## Medical Evaluation Request and Questionnaire for Users of N95 Disposable Respirators\*

### Medical Evaluation Request

1. Today's date \_\_\_\_\_
2. Your age (to nearest year) \_\_\_\_\_
3. Your height \_\_\_\_\_ feet \_\_\_\_\_ inches
4. Your weight \_\_\_\_\_ pounds
5. Your job title \_\_\_\_\_
6. A phone number where you can be reached by the health-care professional who reviews this questionnaire (include area code) \_\_\_\_\_
7. The best time to phone you at this number \_\_\_\_\_
8. Have you worn a respirator? ☐ Yes ☐ No  
If "yes", what types? \_\_\_\_\_
9. Check the type of respirator you will use (check all that apply)
  - ☐ N-, R-, or P- disposable respirator (filter-mask, non-cartridge type only)
  - ☐ Half face-piece type
  - ☐ Full face-piece type
  - ☐ Powered air-purifying respirator (PAPR) – tight-fitting
  - ☐ PAPR – loose-fitting
  - ☐ Other type (supplied-air or self-contained breathing apparatus)

Yes No

- |                          |                          |                                                                        |
|--------------------------|--------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | f. Shortness of breath that interferes with your job                   |
| <input type="checkbox"/> | <input type="checkbox"/> | g. Coughing that produces phlegm (thick sputum)                        |
| <input type="checkbox"/> | <input type="checkbox"/> | h. Coughing that wakes you early in the morning                        |
| <input type="checkbox"/> | <input type="checkbox"/> | i. Coughing that occurs primarily when you are lying down              |
| <input type="checkbox"/> | <input type="checkbox"/> | j. Coughing up blood in the last month                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | k. Wheezing                                                            |
| <input type="checkbox"/> | <input type="checkbox"/> | l. Wheezing that interferes with your job                              |
| <input type="checkbox"/> | <input type="checkbox"/> | m. Chest pain when you breathe deeply                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | n. Any other symptoms that you think might 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 have been told about

### Questionnaire for Users of N95 Respirators

Yes No

- |                          |                          |                                                                                                    |
|--------------------------|--------------------------|----------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Do you currently or have you smoked tobacco during the previous month? If "yes"                 |
|                          |                          | a. At what age did you start smoking? _____                                                        |
|                          |                          | b. How long ago did you quit smoking? _____                                                        |
|                          |                          | c. How many packs per day did or do you smoke? _____                                               |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Have you ever had any of the following conditions?                                              |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Seizures                                                                                        |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Diabetes                                                                                        |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Allergic reactions that interfere with your breathing                                           |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Claustrophobia (fear of closed-in places)                                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Trouble smelling odors                                                                          |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Have you ever had any of the following pulmonary or lung problems?                              |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Asbestosis                                                                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Asthma                                                                                          |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Chronic bronchitis                                                                              |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Emphysema                                                                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Pneumonia                                                                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | f. Tuberculosis                                                                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | g. Silicosis                                                                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | h. Pneumothorax (collapsed lung)                                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | i. Lung Cancer                                                                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | j. Broken ribs                                                                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | k. Any chest injuries or surgeries                                                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | l. Any other lung problem that you have been told about                                            |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you currently have any of the following symptoms of pulmonary or lung illness?               |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Shortness of breath                                                                             |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Shortness of breath when walking quickly on level ground or walking up a slight hill or incline |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Shortness of breath when walking with other people at an ordinary pace on level ground          |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Have to stop for breath when walking at your own pace on level ground                           |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Shortness of breath when washing or dressing yourself                                           |

- |                          |                          |                                                                                       |
|--------------------------|--------------------------|---------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Have you ever had any of the following cardiovascular or heart problems?           |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Frequent pain or tightness in your chest                                           |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Pain or tightness in your chest during physical activity                           |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Pain or tightness in your chest that interferes with your job                      |
| <input type="checkbox"/> | <input type="checkbox"/> | d. In the previous 2 years, have you noticed your heart skipping or missing a beat?   |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Heartburn or indigestion that is not related to eating                             |
| <input type="checkbox"/> | <input type="checkbox"/> | f. Any other symptom that you think might be related to heart or circulation problems |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you currently take any medications for any of the following problems?           |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Breathing or lung problems                                                         |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Heart trouble                                                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Blood pressure                                                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Seizures                                                                           |

If yes, please list:

- |                          |                          |                                                                                                                                                                                     |
|--------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 8. If you have used a respirator, have you ever had any of the following problems? (If you have never used a respirator, check here <input type="checkbox"/> and go to question 9.) |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Eye irritation                                                                                                                                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Skin allergies or rashes                                                                                                                                                         |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Anxiety                                                                                                                                                                          |
| <input type="checkbox"/> | <input type="checkbox"/> | d. General weakness or fatigue                                                                                                                                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Any other problem that interferes with your use of a respirator                                                                                                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Would you like to talk with the health-care professional who will review this questionnaire about your answers to this questionnaire?                                            |

\* Based on your role, FIT testing may also be required to fulfill regulatory requirements. Please speak with your manager to understand if this applies to you.