APPENDIX G: Medical Questionnaire

Occupational Health Department

Please complete this form and send to Tufts Occupational Health Department at occupationalhealth@tufts.edu.
Do not send to your supervisor. In the Subject line, please write "Respirator Questionnaire" and your campus. The nurse will review the questionnaire and reach out to you with questions. You will be notified when you are cleared to be fit tested to wear a respirator.

OSHA Respirator Medical Evaluation Questionnaire

Please fill in the information as completely as possible and sign at the bottom. Thank You.

Full Name	
Date of Birth	
ID#	
Email address	
Phone #	
Department	
Supervisor Name	
	❒ Male ❒ Female ❒ non-binary

OSHA Respirator Questionnaire & Medical Clearance Release & Waiver

I understand the sole purpose of this evaluation is to evaluate my physical ability to wear a respirator (pursuant to the Fit and Medical Evaluation defined in OSHA regulation 29CFR1910.134). I understand that I will be asked to complete the Mandatory OSHA questionnaire and that I may be required to have further testing or examination by Tufts Occupational Health Services staff and/or to supply additional documentation from my healthcare provider. I understand I may be contacted to provide additional information.

I hereby authorize the examining medical professional to provide the results of my evaluation, medical/occupational questionnaire, and my other relevant screening information to Tufts University and/or other entities authorized by law to receive the information. I understand my medical information

will be kept confidential and only my ability to safely wear a respirator will be released.

I further understand that the examiner is not my doctor and that this medical professional is evaluating me solely regarding my ability to perform the functions of a specific job. I understand that the examiner has no obligation to me as a patient.

Name: **Today's Date:**

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)
To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.
To the employee:
Can you read (check one): ❒Yes ❒No
If you cannot read, the questionnaire will be read to you by an Occupational Health Professional. If you need a translator, one will be provided for you.
Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. **(Mandatory)** The following information must be provided by every employee who has been selected to use any type of respirator **(please print).**

Today's date:

Your name:

Your age:

Sex (check one): ❒Male ❒Female ❒non-binary

Your height: feet inches

Your weight: lbs.

Your job title:

A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):

The best time to phone you at this number:

Has your employer/school told you how to contact the health care professional who will review this questionnaire? (Check one): ❒Yes ❒No

Have you worn a respirator? (Check one): ❒Yes ❒No

If "yes," what type(s)?

Part A. Section 2. (Mandatory) Questions 1 through 8 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").	**Yes**	**No**
Do you **currently** smoke tobacco, or have you smoked tobacco in the last month?		
Have you **ever had** any of the following conditions?		
Seizures (fits)?		
Diabetes (sugar disease)?		
Allergic reactions that interfere with your breathing?		
Claustrophobia (fear of closed-in places)?		
Trouble smelling odors?		
Have you **ever had** any of the following pulmonary or lung problems?		
Asbestosis?		
Asthma?		
Emphysema?		
Pneumonia?		
Tuberculosis?		
Silicosis?		
Pneumothorax (collapsed lung)?		
Lung cancer?		
Broken ribs?		
Any other lung problem that you've been told about?		

Do you **currently** have any of the following symptoms of pulmonary or lung illness?		
Shortness of breath?		
Shortness of breath when walking fast on level ground or walking up a slight hill or incline?		
Shortness of breath when walking with other people at an ordinary pace on level ground?		
Have to stop for breath when walking at your own pace on level ground?		
Shortness of breath when washing or dressing yourself?		
Shortness of breath that interferes with your job.		
Coughing that produces phlegm (thick sputum)?		
Coughing that wakes you early in the morning?		
Coughing that occurs mostly when you are lying down?		
Coughing up blood in the last month?		
Wheezing?		
Wheezing that interferes with your job?		
Chest pain when you breathe deeply?		
Any other symptoms that you think may be related to lung problems?		
Have you **ever had** any of the following cardiovascular or heart problems?		
Heart attack?		
Stroke?		
Angina?		
Heart failure?		
Swelling in your legs or feet (not caused by walking)?		
Heart arrhythmia (heart beating irregularly)?		
High blood pressure?		

Any other heart problem that you've been told about?		
Have you **ever had** any of the following cardiovascular or heart symptoms?		
Frequent pain or tightness in your chest?		
Pain or tightness in your chest during physical activity?		
Pain or tightness in your chest that interferes with your job?		
In the past two years, have you noticed your heart skipping or missing a beat?		
Heartburn or indigestion that is not related to eating?		
Any other symptoms that you think may be related to heart or circulation problems?		
Do you **currently** take medication for any of the following problems?		
Breathing or lung problems?		
Heart trouble?		
Blood pressure?		
Seizures (fits)?		
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?		
Skin allergies or rashes?		
Anxiety?		
General weakness or fatigue?		
Any other problem that interferes with your use of a respirator?		
Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?		

If you checked "Yes" to any of the questions above, please explain here:

For Occupational Health only:

❒ Cleared ❒ Not Cleared, needs additional testing

Comments:

Name of Occupational Health professional reviewer:

Date of Review: