



STUDENT HEALTH & COUNSELING

Respirator Medical Evaluation Questionnaire

OSHA Standard 1910.134 AppC

This two-sided questionnaire needs to be completed and signed by each student who will need respiratory protection.

SHAC use only: ___/___/___

- Cleared
Not Cleared

Reviewer Signature:

SECTION ONE:

- 1. Can you read (circle one): YES NO
2. UNM ID Number:
3. Last Name: First: MI: 4. Date:
5. Birth Date: 6. Age: 7. Sex (circle one): Male Female
8. Your height: ft. in. 9. Your weight: lbs.
10. Your job title: 11. Department:
12. A phone number to reach you: 13. The best time to phone you:
14. Check the type of respirator you will use (you can check more than one category):
a. (Tb protection) N95 (N, R or P disposable filter-mask, non-cartridge type only)
b. Other type: powered-air purifying (PAPR) half-facepiece type Other:
NOTE: full-facepiece respirator or a self-contained breathing apparatus (SCBA) medical clearance require additional evaluation.
15. Have you worn a respirator? If "yes," what type(s): YES NO
16. Do you have a beard, moustache, long side burns, or other facial hair? YES NO

QUESTIONS 1-9 below must be answered by every student using any respirator:

Table with 3 columns: Question, YES, NO. Contains questions 1-9 regarding smoking, medical conditions, and lung problems.

(CONTINUE ON OTHER SIDE)

Respirator Medical Evaluation Questionnaire - Continued

4. Do you currently have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath:	YES	NO
b. Have you stopped for breath when walking at your own pace on level ground:	YES	NO
c. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	YES	NO
d. Shortness of breath when walking 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 that interferes with your job:	YES	NO
k. Chest pain when breathe deeply:	YES	NO
l. Any other symptoms that you think may be related to lung problems:	YES	NO
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: _____	YES	NO
6. Have you ever had any of the following cardiovascular or heart symptoms?		
a. Frequent pain or tightness in your chest:	YES	NO
b. Pain or tightness in your chest during physical activity:	YES	NO
c. Pain or tightness in your chest that interferes with your job:	YES	NO
d. In the past two years, have you noticed your heart skipping or missing a beat:	YES	NO
e. Heartburn or indigestion that is not related to eating:	YES	NO
f. Any other symptoms that you think may be related to heart or circulation problems: _____	YES	NO
7. Do you currently take medication 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
8. Has your wearing a respirator caused any of the following problems? If you have never used a respirator, check (✓) here: _____ and go to question #9:		
a. Eye irritation:	YES	NO
b. Skin allergies or rashes:	YES	NO
c. Anxiety (that only occurs when you use the respirator):	YES	NO
d. General weakness or fatigue, unusual weakness or fatigue:	YES	NO
e. Any other problem that interferes with your use of a respirator: _____	YES	NO
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? If yes, contact information: _____		
	YES	NO

I certify that the above information is correct: Printed Student Name: _____

Student Signature: _____ Date: _____