SENTARA®

OCCUPATIONAL HEALTH SERVICES

Pre-Placement Health Assessment and OSHA Medical Questionnaire for Respirator Use

Source *of Duplication: OSHA Respiratory Protection Standards, 1910.134 Appendix C, OSHA Respirator Medical Evaluation Questionnaire*

Name: Last _____ First _____ MI____ DOB_____ Gender ☐M ☐F

Job Title _____ Primary Location: Select a Location Email: _____

Do you have any allergies? ☐Yes ☐No If Yes, please list: _____

Are you sensitive to latex? ☐Yes ☐No If Yes, please describe: _____

Do you have a chronic skin condition? ☐Yes ☐No If Yes, please describe: _____

Do you currently have an open lesion? ☐Yes ☐No If Yes, please describe: _____

List any medications currently taking: ☐Yes ☐No _____

Please list dates and types of surgeries you have had in the last 5 years (other than sterilization or C-section)
If no surgeries, write "none" _____

Are you currently under any physical or medical restrictions? ☐Yes ☐No If Yes, please describe:

_____

Have you ever received Workers' Compensation (medical bills and/or wages) for a work-related injury? ☐Yes ☐No

(Mandatory) Every employee who has been selected to use any type of respirator must provide the requested information that follows.

Completed by: ☐Self ☐Interviewer Interviewer's initials _____

Have you ever had any of the following conditions?	Yes	No
Hearing problems	☐	☐
Allergic reactions that interfere with your breathing	☐	☐
Claustrophobia (fear of closed-in places)	☐	☐
Hernia	☐	☐
Trouble smelling odors	☐	☐
Positive TB skin test (convertor)	☐	☐
Vision problems (color or night blindness, blurred vision, glaucoma, cataract, other)	☐	☐
Have you ever had any of the following cardiovascular or heart symptoms?	**Yes**	**No**
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	☐	☐
Other than those already discussed, please list any symptoms that you think may be related to heart or circulation problems. If none, please write "none." _____		

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

	Yes	No		Yes	No
Asbestosis	☐	☐	Tuberculosis (TB)	☐	☐
Asthma	☐	☐	Silicosis	☐	☐
Chronic bronchitis	☐	☐	Collapsed lung	☐	☐
Emphysema	☐	☐	Lung Cancer	☐	☐
Pneumonia	☐	☐			

Do you currently have any of the following musculoskeletal problems?

	Yes	No		Yes	No
Weakness or pain in arms, legs, hands, feet, wrist, or ankles	☐	☐	Difficulty fully moving your head up or down	☐	☐
Back Pain	☐	☐	Difficulty fully moving your head side to side	☐	☐
Broken ribs	☐	☐	Difficulty bending your knees	☐	☐
Difficulty fully moving your arms and legs	☐	☐			

Vision information section will be completed by an Occupational Health Nurse

Vision	Right (drivers)	Left (drivers)	Both	Color Vision	Ht	Wt	B/P
W or **W/O** correction							
Near							
Far							

Do you have and/or currently take medication for any of the following health conditions?	Yes	No	Medications
Heart problems (heart attack, CHF, cardiomyopathy, arrhythmia)	☐	☐	
Stroke	☐	☐	
Swelling in your legs or feet (not caused by walking)	☐	☐	
High blood pressure	☐	☐	
Breathing or lung problems	☐	☐	
Seizures	☐	☐	
Diabetes	☐	☐	
Migraine or other frequent headaches	☐	☐	
Kidney disease	☐	☐	
Thyroid disease	☐	☐	
Bleeding Disorder	☐	☐	
Hepatitis or other liver disease	☐	☐	
Tumor or cancer	☐	☐	
Depression, emotional disorder or history of ADHD or ADD	☐	☐	
Autoimmune or immunosuppressive disorder	☐	☐	
List any additional health conditions that require medication	☐	☐	

Do you currently have any of the following symptoms of pulmonary or lung illness?	Yes	No
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? Does it interfere with your job?	☐	☐
Chest pain when you breathe deeply	☐	☐
Please list any chest injuries, surgeries or other lung-related symptoms or problems you might have. If none, please state "none." _____		

Have you ever experienced the following while using a respirator?	Yes	No
Eye irritation	☐	☐
Skin allergies or rashes	☐	☐
Unusual anxiety	☐	☐
General weakness or fatigue	☐	☐

Check the type of respirator(s) you will use (you can check more than one category):

☐ N disposable respirator (filter-mask, non- cartridge type) TB Respirator
☐ P disposable respirator (filter-mask, non- cartridge type)
☐ R disposable respirator (filter-mask, non- cartridge type)
☐ PAPR (powered-air purifying respirator)

What type(s) of respirator(s) have you worn in the past? _____

Statement of Understanding Regarding Pre-Placement Screen

The answers that I have given regarding my health status are true to the best of my knowledge. Falsification of any information in the questionnaire will result in termination. I understand that the information will be used to determine whether I am capable of performing the physical requirements of the position for which I am being considered. My full name below indicates my understanding of the above statements regarding my pre-placement health screen.

Full Name | *Phone Number* | *Today's Date*

FOR OFFICE USE ONLY: TO BE COMPLETED BY OCCUPATIONAL HEALTH

NURSE **Cleared for fit test by Licensed Healthcare Professional:**

N95 (TB Respirator) ☐ Yes ☐ No ☐ N/A

PAPR/Full Face ☐ Yes ☐ No ☐ N/A

Reviewed with Medical Advisor? ☐ Yes ☐ No ☐ N/A

Applicant's SSN _____

OHN Full Name _____

Today's Date _____

Submit Form

Revised August 11, 2016