SENTARA

OCCUPATIONAL HEALTH SERVICES
MEDICAL QUESTIONNAIRE FOR RESPIRATOR USE

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

Hospital: ☐ SBH ☐ SCH ☐ SLH ☐ SNGH ☐ SVBGH ☐ SWCH

Other Sentara Location:

Department:

TO BE COMPLETED BY OCCUPATIONAL HEALTH NURSE:

Date:

Interviewed by: Nurse

Reviewed with Medical Advisor: ☐ Yes ☐ N/A

Cleared for fit test::

N-95 Respirator ☐ Yes ☐ No ☐ N/A

Full or Half Face Respirator ☐ Yes ☐ No ☐ N/A

Please print your answers.

1. Today's date:
2. Your name:
3. Your Employee ID Number: SSN:
4. Your age (to nearest year): Date of Birth:
5. Sex: Male Female
6. Your height: ft. in. Your weight: lbs.
7. Your job title: Work Loc./Site/Dept.:
8. 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 contact you at this number:
9. Has your employer told you how to contact the health care professional who will review this questionnaire:
   Yes No
10. Check the type of respirator you will use (you can check more than one category):

    a. N, R, or P disposable respirator (filter-mask, non- cartridge type only).

    b. Other type (for example, half or full-face piece type, powered air purifying, supplied-air, self-contained breathing apparatus).
11. Have you worn a respirator: Yes No

    If "yes," what type(s):