Respiratory Protection Plan	

OSHA MEDICAL QUESTIONNAIRE

PART 1. PERSONAL INFORMATION

Date: Nov 17, 2020 Name: Mickey (first) (middle) Mouse (last)			SSN: 123-45-6789
Age: 35	Sex (circle one): (Male) Female	Height: 5 ft. 3 in.	Weight: 115 lbs.
Job Title: Entertainment Consultant		Department: Disney Inc.	
A phone number where you can be reached by the healthcare professional who reviews this questionnaire: 804-123-4567 The best time to phone you at this number: anytime			
Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): (Yes)/No			
Type of respirator(s) you will be using (if known): N95 Have you worn a respirator in the past? (circle one): Yes/(No) If "yes," what type(s):			

PART 2. HEALTH QUESTIONS

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. Please circle "yes" or "no" to the following.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes/(No)

2. Have you ever had any of the following conditions?
   - a. Seizures (fits): Yes/(No)
   - b. Diabetes (sugar disease): Yes/(No)
   - c. Allergic reactions that interfere with your breathing: Yes/(No)
   - d. Claustrophobia (fear of closed-in places): Yes/(No)
   - e. Trouble smelling odors: Yes/No

3. Have you ever had any of the following pulmonary or lung problems?
   - a. Asbestosis: Yes/(No)
   - b. Asthma: Yes/(No)
   - c. Chronic bronchitis: Yes/(No)
   - d. Emphysema: Yes/(No)
   - e. Pneumonia: Yes/(No)
   - f. Tuberculosis: Yes/(No)
   - g. Silicosis: Yes/(No)
   - h. Pneumothorax (collapsed lung): Yes/(No)
   - i. Lung cancer: Yes/(No)
   - j. Broken ribs: Yes/(No)
   - k. Any chest injuries or surgeries: Yes/(No)
   - l. Any other lung problem that you've been told about: Yes/(No)

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

   a. Shortness of breath: Yes/No (No circled)
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No (No circled)
   c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No (No circled)
   d. Have to stop for breath when walking at your own pace on level ground: Yes/No (No circled)
   e. Shortness of breath when washing or dressing yourself: Yes/No (No circled)
   f. Shortness of breath that interferes with your job: Yes/No (No circled)
   g. Coughing that produces phlegm (thick sputum) not associated with a cold: Yes/No (No circled)
   h. Coughing that wakes you early in the morning: Yes/No (No circled)
   i. Coughing that occurs mostly when you are lying down: Yes/No (No circled)
   j. Coughing up blood in the last month: Yes/No (No circled)
   k. Wheezing: Yes/No (No circled)
   l. Wheezing that interferes with your job: Yes/No (No circled)
   m. Chest pain when you breathe deeply: Yes/No (No circled)
   n. Any other symptoms that you think may be related to lung problems: Yes/No (No circled)

5. Have you ever had any of the following cardiovascular or heart problems?
   a. Heart attack: Yes/No (No circled)
   b. Stroke: Yes/No (No circled)
   c. Angina: Yes/No (No circled)
   d. Heart failure: Yes/No (No circled)
   e. Swelling in your legs or feet (not caused by walking): Yes/No (No circled)
   f. Heart arrhythmia (heart beating irregularly): Yes/No (No circled)
   g. High blood pressure: Yes/No (No circled)
   h. Any other heart problem that you've been told about: Yes/No (No circled)

6. Have you ever had any of the following cardiovascular or heart symptoms?
   a. Frequent pain or tightness in your chest: Yes/No (No circled)
   b. Pain or tightness in your chest during physical activity: Yes/No (No circled)
   c. Pain or tightness in your chest that interferes with your job: Yes/No (No circled)
   d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No (No circled)
   e. Heartburn or indigestion that is not related to eating: Yes/No (No circled)
   f. Any other symptoms you think may be related to heart or circulation problems: Yes/No (No circled)

7. Do you currently take medication for any of the following problems?
   a. Breathing or lung problems: Yes/No (No circled)
   b. Heart trouble: Yes/No (No circled)
   c. Blood pressure: Yes/No (No circled)
   d. Seizures (fits): Yes/No (No circled)
   e. Other None

8. If you've used a respirator, have you ever had any of the following problems? (If you've 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: Yes/No
    d. General 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 healthcare professional who will review this questionnaire about your answers to this questionnaire? Yes/No

The individual who is to wear a respirator must complete this form. Part 1 is completed by filling in the personal information requested.

Part 2 has nine yes/no questions that must be answered.

Once Part 1 and Part 2 are completed, this form should be shared with and reviewed by a physician or other licensed health care professional (PLHCP).

NOTE 1: A physician or other licensed health care professional (PLHCP) is defined by OSHA as an individual whose legally permitted scope of practice (i.e., license, registration, or certification) allows him or her to independently provide, or be delegated the responsibility to provide, some or all of the health care services required by paragraph (e) of 29 CFR 1910.134.

NOTE 2: A PLHCP may be a physician, registered nurse, nurse practitioner, or physician assistant.