

| OSHA/NPPTL Medical Evaluation: Annually for all Test Participants<br>Rev 1 (10.25.2023) |                               |                                 |
|-----------------------------------------------------------------------------------------|-------------------------------|---------------------------------|
| <b>Your name</b> ( <i>Last, First, Middle Initial</i> ) :                               |                               |                                 |
| <b>Part A.</b>                                                                          | <b>Your Answer</b>            |                                 |
| 1. Today's date ( <i>MM/DD/YYYY</i> ) :                                                 | / /                           |                                 |
| 2. Birth Date ( <i>MM/DD/YYYY</i> ) :                                                   | / /                           |                                 |
| 3. Biological Sex:                                                                      | <input type="checkbox"/> Male | <input type="checkbox"/> Female |
| 4. Your height:                                                                         | ft.                           | in.                             |
| 5. Your weight:                                                                         | lbs.                          |                                 |
| 6. Your occupation:                                                                     |                               |                                 |
| 7. Your phone number                                                                    | ( ) -                         |                                 |
| 8. The best time to phone you ( <i>morning, afternoon, evening, any</i> )               |                               |                                 |
| 9. Have you worn a respirator previously?                                               | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| If "Yes", how many years of experience wearing respirators?                             | Years                         |                                 |
| If "Yes", what types of respirators have you worn/used?                                 |                               |                                 |
| <b>Part B.</b>                                                                          | <b>Your Answer</b>            |                                 |
| 1. Do you <i>currently</i> smoke tobacco, or have you smoked tobacco in the last month: | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| 2. Have you <i>ever had</i> any of the following conditions?                            |                               |                                 |
| a. Seizures:                                                                            | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| b. Diabetes:                                                                            | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| c. Allergic reactions that interfere with your breathing:                               | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| d. Claustrophobia (fear of closed-in places):                                           | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| e. Trouble smelling odors:                                                              | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| 3. Have you ever had any of the following pulmonary or lung problems?                   |                               |                                 |
| a. Asbestosis:                                                                          | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| b. Asthma:                                                                              | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| c. Chronic bronchitis:                                                                  | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| d. Emphysema:                                                                           | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| e. Pneumonia:                                                                           | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| f. Tuberculosis:                                                                        | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| g. Silicosis:                                                                           | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| h. Pneumothorax (collapsed lung):                                                       | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| i. Lung cancer:                                                                         | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| j. Broken ribs:                                                                         | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| k. Any chest injuries or surgeries:                                                     | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| l. Any other lung problem that you've been told about:                                  | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| 4. Do you currently have any of the following symptoms of pulmonary or lung illness?    |                               |                                 |
| a. Shortness of breath ( <b>SOB</b> ):                                                  | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| b. SOB when walking fast on level ground or walking up a slight hill:                   | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |
| c. SOB when walking at an ordinary pace on level ground:                                | <input type="checkbox"/> Yes  | <input type="checkbox"/> No     |

|                                                                                                                                             |                              |                             |
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| d. Have to stop for breath when walking on level ground:                                                                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. SOB when washing or dressing yourself:                                                                                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. SOB that interferes with your job:                                                                                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Coughing that produces phlegm (thick sputum): <input type="checkbox"/>                                                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Coughing that wakes you early in the morning:                                                                                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Coughing that occurs mostly when you are lying down:                                                                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Coughing up blood in the last month:                                                                                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k. Wheezing:                                                                                                                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| l. Wheezing that interferes with your job:                                                                                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| m. Chest pain when you breathe deeply:                                                                                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| n. Any other symptoms that you think may be related to lung problems:                                                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Have you <i>ever had</i> any of the following cardiovascular or heart problems?                                                          |                              |                             |
| a. Heart attack:                                                                                                                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Stroke:                                                                                                                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Angina:                                                                                                                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Heart failure:                                                                                                                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Swelling in your legs or feet (not caused by walking):                                                                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Heart arrhythmia (heart beating irregularly):                                                                                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. High blood pressure:                                                                                                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Any other heart problem that you've been told about:                                                                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Do you <i>currently have</i> any of the following cardiovascular or heart symptoms?                                                      |                              |                             |
| a. Frequent pain or tightness in your chest:                                                                                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Pain or tightness in your chest during physical activity:                                                                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Pain or tightness in your chest that interferes with your job:                                                                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. In the past 2 years, has your heart skipped or missed a beat:                                                                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Heartburn or indigestion that is not related to eating:                                                                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Any symptoms you think may be related to heart or circulation problems:                                                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Do you <i>currently</i> take medication for any of the following problems?                                                               |                              |                             |
| a. Breathing or lung problems:                                                                                                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Cardiovascular or Heart trouble:                                                                                                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Blood pressure:                                                                                                                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Seizures:                                                                                                                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. If you've used a respirator, have you <i>ever had</i> any of the following? (If you've never used a respirator, select no and go to # 9) |                              |                             |
| a. Eye irritation:                                                                                                                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Skin allergies or rashes:                                                                                                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Anxiety:                                                                                                                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. General weakness or fatigue:                                                                                                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Any other problem that interferes with your use of a respirator: <input type="checkbox"/>                                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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