

OSHA/NPPTL Medical Evaluation: Annually for all Test Participants		
Rev 1 (10.25.2023)		
Your name (Last, First, Middle Initial) :		
Part A.		Your Answer
1. Today's date (MM/DD/YYYY) :	/ /	
2. Birth Date (MM/DD/YYYY) :	/ /	
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?		
Part B.		Your Answer
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 (SOB):	<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

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 take</i> 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

