Form Approved
OMB No. 0920-0109
Exp. Date xx/xx/20xx

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:	☐ Male	☐ Female
4. Your height:	ft.	in.
5. Your weight:		lbs.
6. Your occupation:		
7. Your phone number	( ) -	
8. The best time to phone you *(morning, afternoon, evening, any)*		
9. Have you worn a respirator previously?	☐ Yes	☐ 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 *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:	☐ Yes	☐ No
b. Diabetes:	☐ 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 **(SOB)**:	☐ Yes	☐ No
b. SOB when walking fast on level ground or walking up a slight hill:	☐ Yes	☐ No
c. SOB when walking at an ordinary pace on level ground:	☐ Yes	☐ No

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

PARTICIPANT STOP HERE

Health Care Professional:

In accordance with good clinical practice, all abnormal answers to clinical signs or symptoms in the clinical history form should be followed up with additional questions to clearly document the clinical significance of the reported abnormal condition. While in many cases adequate information may be obtained with simple follow-up probes, in other cases (such as any chest pain) a rather detailed history may be necessary. The health care professional is expected to use good clinical judgment in this process.

Evaluation notes (address abnormal findings):

☐ No exclusions identified ☐ Excluded from participation

Health Care Professional Printed Name: _____

Health Care Professional Signature: _____

Date (MM/DD/YYYY): _____