ORLANDO VAHCS ANNUAL RESPIRATOR MEDICAL QUESTIONNAIRE

(FOR ANNUAL FIT-TESTING ONLY – NOT FOR USE FOR INITIAL FIT-TESTING) IAW 29 CFR 1910.134

EMPLOYEE

LAST, FIRST NAME			
SERVICE		**EMPLOYEE PHONE**	
OCCUPATION		**SUPERVISOR NAME**	
LOCATION			
EMPLOYEE EMAIL			

Answer all questions stated bellow. Any YES answer will automatically be referred to the Occupational Health for reevaluation: (1910.134(e)(7)(ii))

1. Do you have or have you developed in the past year any symptoms of pulmonary or lung illness (such as, shortness of breath, chest pains, coughing phlegm or blood, or any diagnosed illness)? **YES** ____ **NO** ____ (1910.134(e)(7)(i))

2. Do you have or have you developed in the past year any adverse cardiovascular or heart symptoms (such as, frequent chest pains or tightness, skipped or missed beats, heartburn not related to eating)? **YES** ____ **NO** ____ (1910.134(e)(7)(i))

3. Are there any changes in your work environment or task that involves respirator use that increases the physiological burden on you (such as, temperature increase, additional protective clothing, or PPE, etc.)?
   YES ____ **NO** ____ (1910.134(e)(7)(iv))

4. Do you feel you need to see a physician about any respiratory medical problems that may affect your ability to wear a respirator?
   YES ____ **NO** ____

5. Have you gained or lost approximately 10% of your body weight since your last fit test?
   YES ____ **NO** ____ What is your present weight? _____ lbs.

6. Have there been any change in the size or shape of neck, head, or mouth:
   YES____**NO**____

7. Have you had issues with Claustrophobia (fear of closed-in places) in the past year?
   YES____**NO**____

EMPLOYEE SIGNATURE: _____

DATE: _____