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 <i>(morning, afternoon, evening, any)</i>		<i></i>	
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?		10015	
Part B.	Yo	ur Answer	
1. Do you <i>currently</i> smoke tobacco, or have you smoked tobacco in			
the last month:	□ Yes	□ No	
2. Have you <i>ever had</i> any of the following conditions?	_ 100		
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 problem			
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	
1. 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	\square No	
c. SOB when walking at an ordinary pace on level ground:	□ Yes	□ No	

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSD Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0109).

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
1. 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 pro	blems?	
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 <i>currently have</i> any of the following cardiovascular or heart	symptoms?	
a. Frequent pain or tightness in your chest:	□ Yes	\square 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	
7. Do you <i>currently</i> take medication for any of the following problems		I_ >*
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 <i>ever had</i> any of the	_ **	_ > 7
following? (If you've never used a respirator, select no and go to # 9)	□ Yes	□ No
a. Eye irritation:	□ Yes	
b. Skin allergies or rashes:	□ Yes	
c. Anxiety:	□ Yes	
d. General weakness or fatigue:	□ Yes	□ No
e. Any other problem that interferes with your use of a		
respirator:	□ Yes	\square 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 clear the clinical history form should be followed up with additional quest clinical significance of the reported abnormal condition. While in mainformation may be obtained with simple follow-up probes, in other pain) a rather detailed history may be necessary. The health care progood clinical judgment in this process.	ions to clearl any cases ade cases (such a	y document the quate s any chest		
Evaluation notes (address abnormal findings):				
\square No exclusions identified \square Excluded from participation				
Health Care Professional Printed Name:				
Health Care Professional Signature:				
Date (MM/DD/YYYY):				