Respirator Medical Evaluation Questionnaire

The following information must be provided by every employee who has been selected to use any type of Respirator.

Personal Information - Part A Section 1. (Mandatory)

Full Name: _____ Today's Date: _____
Last *First* *M.I.*

Age: _____ Sex: ☐ Male/☐ Female
(to nearest year)

Height: _____ **ft.** _____ **in.** Weight: _____ lbs

Job Title: _____ Phone _____

A phone number where you can be reached by the healthcare professional who reviews this questionnaire (Inc. Area Code).
Best time to phone this number _____

Has your employer told you how to contact the healthcare professional who will review this questionnaire (circle one): **Yes/No**

Check the type of respirator you will use (you can check more than one category)

a.☐ N, R, or P disposable respirator (filter mask, Non-Cartridge type only).

b._____ Other type (for example, half or full facepiece type, powered- air purifying, supplied-air, self-contained breathing apparatus).

Have you worn a respirator (circle one): **Yes/No** If "Yes" what type(s): _____

Part A. Section 2. (Mandatory)

*Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. (please circle **Yes** or **No**).*

	YES	NO
1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month?	☐	☐
2. Have you *ever* had any of the following conditions?	YES ☐	NO ☐
a. Seizures	☐	☐
b. Diabetes (sugar disease)	☐	☐
c. Allergic reactions that interfere with your breathing	☐	☐
d. Claustrophobia (fear of closed-in places)	☐	☐
e. Trouble smelling odors.	☐	☐

	YES	NO
3. Have you *ever* had any of the following pulmonary or lung problems?	☐	☐
a. Asbestosis	☐	☐
b. Asthma	☐	☐
c. Chronic Bronchitis	☐	☐
d. Emphysema	☐	☐
e. Pneumonia	☐	☐
f. Tuberculosis	☐	☐
g. Silicosis	☐	☐
h. Pneumothorax (collapsed lung)	☐	☐
i. Lung cancer	☐	☐
j. Broken ribs	☐	☐
k. Any chest injuries or surgeries	☐	☐
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	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground	☐	☐
d. Have to stop for breath when walking at your own pace on level ground	☐	☐
e. Shortness of breath when washing or dressing yourself	☐	☐
f. Shortness of breath that interferes with your job	☐	☐
g. Coughing that produce phlegm (thick sputum)	☐	☐
h. Coughing that wakes you early on a morning	☐	☐
i. Coughing that occurs mostly when you are lying down	☐	☐
j. Coughing up blood in the last month	☐	☐
k. Wheezing	☐	☐

l. Wheezing that interferes with your job	☐	☐
m. Chest pain when you breathe deeply	☐	☐
n. Any other symptoms that you think may be related to lung problems	☐	☐
5. Have you *ever* had any of the following cardiovascular or heart problems?	YES ☐	NO ☐
a. Heart Attack	☐	☐
b. Stroke	☐	☐
c. Angina	☐	☐
d. Heart failure	☐	☐
e. Swelling in your legs or feet (not caused by walking)	☐	☐
f. Heart arrhythmia (heart beating irregularly)	☐	☐
g. High blood pressure	☐	☐
h. Any other heart problem that you've been told about	☐	☐
6. Have you *ever* had any of the following cardiovascular or heart symptoms?	YES ☐	NO ☐
a. Frequent pain or tightness in your chest	☐	☐
b. Pain or tightness in your chest during physical activity	☐	☐
c. Pain or tightness in your chest that interferes with your job	☐	☐
d. In the past two years, have you noticed your heart skipping or missing a beat	☐	☐
e. Heartburn or indigestion that is not related to eating	☐	☐
f. Any other symptoms that you think may be related to heart or circulation problems	☐	☐
7. Do you *currently* take medications for any of the following problems?	YES ☐	NO ☐
a. Breathing or lung problems	☐	☐
b. Heart trouble	☐	☐
c. Blood pressure	☐	☐
d. Seizures	☐	☐

	YES	NO
8. If you've used a respirator, have you *ever* had any of the following problems?	☐	☐
(If you've never used a respirator, check the following space and go to question 9.	☐	☐
a. Eye irritation	☐	☐
b. Skin allergies or rashes	☐	☐
c. Anxiety	☐	☐
d. General weakness or fatigue	☐	☐
e. Any other problem that interferes with your use of a respirator	☐	☐
9. Would you like to talk to the health care professional who will review this questionnaire about the answers to this questionnaire?	☐	☐
10. Have you *ever* lost vision in either eye (temporarily or permanently)?	☐	☐
11. Do you *currently* have any of the following vision problems?	☐	☐
a. Wear contact lenses	☐	☐
b. Color blind	☐	☐
c. Any other eye problems	☐	☐
12. Have you *ever* had any injury to your ears, including a broken ear drum?	☐	☐
13. Do you *currently* have any of the following hearing problems?	☐	☐
a. Difficulty hearing	☐	☐
b. Wearing a hearing aid	☐	☐
c. Any other hearing or ear problems	☐	☐
14. Have you *ever* had a back injury?	☐	☐
15. Do you *currently* have any of the following musculoskeletal problems?	☐	☐
a. Weakness in any of your arms, hands, legs, or feet	☐	☐
b. Back pain	☐	☐
c. Difficulty fully moving your arms and legs	☐	☐

d. Pain and stiffness when you lean forward or backward at the waist	☐	☐
e. Difficulty fully moving your head up or down	☐	☐
f. Difficulty fully moving your head side to side	☐	☐
g. Difficulty bending at your knees	☐	☐
h. Difficulty squatting to the ground	☐	☐
i. Climbing a flight of stairs or a ladder carrying more than 25lbs.	☐	☐
j. Any other muscle or skeletal problem that interferes with using a respirator		

Healthcare Providers Signature

I certify that my answers are true and complete to the best of my knowledge.

Signature: _____ Date: _____

Medical Facility: _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

Signature: _____ Date: _____