Respirator Medical Evaluation Questionnaire

IMPORTANT: Employer – please indicate appropriate clearance for employee’s respirator use.

- High Risk/Strenuous work with SCBA
- High Risk (SCBA for escape only)
- Moderate Risk (Full / 1/2 face respirator)
- Low Risk/Dust Mask

Every employee who has been selected to use any type of respirator must provide the following information. (please print)

Name ________________________________ Date __/__/____

DOB ___/___/____ Age ________ Sex ________ Height ________ Weight ________

Department: ________________________ Department Supervisor and Phone:__________________________

Job Title ____________________________ Work Phone or Cell: _____________________ Shift: ______________

Have you been instructed by your employer to contact a health care professional to review this questionnaire with you?  Yes  No

Have you ever worn a respirator?     Yes  No If so, what kind? __________________________________________________

Circle the type of respirator you will use (you can circle 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-face piece type, powdered-air purifying, supplied air, self-contained breathing apparatus).

every employee who has been selected to use any type of respirator must answer questions 1 through 9 below (please circle yes or no to answer the following questions)

1. Have you ever smoked?  Yes  No
   Quit date _______________ # of years you smoked _______________

   Do you currently smoke tobacco? Yes  No
   How many packs per day? _______________ For how many years? ______________

If you answer yes to any of the following questions, please explain on the reverse side of this form.

2. Have you ever had any of the following conditions?
   a. Seizures (fits) Yes  No
   b. Diabetes (sugar disease) 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
   f. Condition that may interfere with face piece sealing Yes  No
      Is it facial hair that interferes with face piece sealing Yes  No
   g. Facial reconstructive or cosmetic surgery Yes  No
   h. Significant facial scarring Yes  No
   i. Weight gain or loss of 20 lbs or more in the past year Yes  No

3. Have you ever had any other following pulmonary or lung problems?
   a. Asbestos 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
   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 produces phlegm (thick sputum)
   h. Coughing that wakes you early in the morning
   i. Coughing that occurs mostly when you are lying down
   j. Coughing up blood
   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?
   a. Heart attack
   b. Swelling in your legs or feet (not caused by walking)
   c. Stroke
   d. Heart arrhythmia (heart beating irregularly)
   e. Angina
   f. High blood pressure
   g. Heart failure
   h. Any other heart problem that you’ve been told about

6. Have you ever had any of the following cardiovascular or heart symptoms?
   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
   g. Do you have a heart murmur
   h. Have you had Rheumatic Fever

7. Do you currently take medication for any other of the following problems?
   a. Breathing or lung problems
   b. Heart trouble
   c. Blood pressure
   d. Seizures (fits)

List any medications, dosages and frequency that you take including over the counter and herbal medicines:
____________________________________________________________________________________________________________

8. If you’ve used a respirator, have you ever had any other of the following problems? (If you have never used a respirator, check the following and go to Question #9). _____ never used a respirator
   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 your answers to this questionnaire? Yes No
10. Have you ever lost vision in either eye (temporarily or permanently)?
   Yes  No

11. Do you currently?
   a. Wear contact lenses
      Yes  No
   b. Wear glasses
      Yes  No
   c. Experience color blindness
      Yes  No
   d. Any other eye or vision condition
      Yes  No

12. Have you ever had an injury to your ears, including a broken ear drum?
    Yes  No

13. Do you currently have any of the following hearing conditions?
   a. Difficulty hearing
      Yes  No
   b. Wear a hearing aid
      Yes  No
   c. Any other hearing or ear problem or condition
      Yes  No

14. Have you ever had a back injury?
    Yes  No

15. Do you currently have any of the following musculoskeletal problems?
   a. Weakness in your arms, hands, legs or feet
      Yes  No
   b. Back pain
      Yes  No
   c. Difficulty fully moving your arms or legs
      Yes  No
   d. Pain or stiffness when you lean forward or backward at the waist
      Yes  No
   e. Difficulty fully moving your head up or down
      Yes  No
   f. Difficulty fully moving your head from side to side
      Yes  No
   g. Difficulty bending at your knees
      Yes  No
   h. Difficulty squatting to the ground
      Yes  No
   i. Difficulty climbing a flight or stairs or ladder carrying more than 25 lbs.
      Yes  No
   j. Any other muscle or skeletal problem that interferes with using a respirator
      Yes  No

16. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes or dust), or have you come into skin contact with hazardous chemicals
    Yes  No
If yes, name the chemicals (if known) and explain the exposures ________________________________________________________

17. At work/home have you ever been worked with or been exposed to the following?
   a. Asbestos
      Yes  No
   b. Solvents
      Yes  No
   c. Silica (e.g. sandblasting)
      Yes  No
   d. Tungsten (i.e. grinding/welding)
      Yes  No
   e. Heavy metals
      Yes  No
   f. Berylline
      Yes  No
   g. Aluminum
      Yes  No
   h. Coal (e.g., mining)
      Yes  No
   i. Iron
      Yes  No
   j. Tin
      Yes  No
   k. Dusty environment
      Yes  No
   l. Any other hazardous exposures
      Yes  No
If yes explain these exposures ____________________________________________________________

List any second jobs, side businesses or hobbies: __________________________________________

List any Military Service ______________________________________________________________

Were you exposed to any biological/chemical agents in training or combat? ___________________

Please send completed questionnaire to Cutler Health Center in a sealed envelope ATTN: Respiratory Evaluation.