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. 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	Yes	No
b.	Shortness of breath when walking fast on level ground or walking up a slight hill or incline	Yes	No
c.	Shortness of breath when walking with other people at an ordinary pace on level ground	Yes	No
d.	Have to stop for breath when walking at your own pace on level ground	Yes	No
e.	Shortness of breath when washing or dressing yourself	Yes	No
f.	Shortness of breath 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	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.	Swelling in your legs or feet (not caused by walking)	Yes	No
c.	Stroke	Yes	No
d.	Heart arrhythmia (heart beating irregularly)	Yes	No
e.	Angina	Yes	No
f.	High blood pressure	Yes	No
g.	Heart failure	Yes	No
h.	Any other heart problem that you've been told about	Yes	No

6. Have you ever had 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 two years, have you noticed your heart skipping or missing a beat	Yes	No
e.	Heartburn or indigestion that is not related to eating	Yes	No
f.	Any other symptoms that you think may be related to heart or circulation problems	Yes	No
g.	Do you have a heart murmur	Yes	No
h.	Have you had Rheumatic Fever	Yes	No

7. Do you currently take medication for any other of the following problems?

a.	Breathing or lung problems	Yes	No
b.	Heart trouble	Yes	No
c.	Blood pressure	Yes	No
d.	Seizures (fits)	Yes	No

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	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 sue of a respirator	Yes	No

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. Beryline	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.