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**Mandatory Respirator Medical Evaluation Questionnaire**

**Employee: Answer all questions on pages 1 through 3**

**Employer:** Answers to questions in Section 1 and to question 9 in Section 2 of Part A do Not require a medical examination.

**EMPLOYER:** \_\_\_\_\_

**Employee:** Can you read? (Circle one) **Yes No**

Your employer must allow you to answer this questionnaire during Normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must Not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

**Part A Section 1. Mandatory**

The following information must be provided by every employee who has been selected to use any type of respirator **Please print:** **SOC. SEC #(Last 4 #'s only):** xxx-xx-\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

1. Today's Date	2. Your Name	3. Your Age (to nearest year)	4. Sex (circle one)	5. Your height	6. Your weight
			M F	ft. ins.	lbs.

7. Your job title: \_\_\_\_\_

8. A phone number where you can be reached by the health care professional who reviews this questionnaire: (include the Area Code) ( ) \_\_\_\_\_

9. The best time to phone you at this number is: \_\_\_\_\_

10. Has your employer told you how to contact the health care professional who will review this questionnaire? (circle one) **Yes No**

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

a. Disposable respirator (filter-mask, Non cartridge type only)

- N (Not resistant)
- R (Resistant)
- P (Proof.oil)

b. Other types

- Half Face Piece  Full Face Piece
- Powered Air Purifying  Supplied Air
- SCBA (self-contained breathing apparatus)
- 

12. Have you worn a respirator? (circle one) **Yes No** If "Yes" what type(s) \_\_\_\_\_

Do you currently wear a respirator? Yes No

If Yes, have you had any medical problems while wearing a respirator? If so, please explain: \_\_\_\_\_

**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.**

1. Do you <i>currently</i> smoke tobacco, or have you smoked tobacco in the last month? If Yes, how many per day _____ How long: _____	Yes	No
2. Have you <i>ever</i> had any of the following conditions?		
a. Seizures (fits): <b>If Yes, last episode date:</b> _____	Yes	No
b. Diabetes (sugar disease): <b>If Yes, is your Diabetes being monitored by a physician? Yes No</b>	Yes	No
c. Allergic reactions that interfere with your breathing: <b>If Yes, last episode date:</b> _____	Yes	No
d. Claustrophobia (fear of closed in places):	Yes	No
<b>If Yes, any problems wearing a respirator? Yes No. If Yes, please explain</b>		
e. Trouble smelling odors: <b>If Yes, does it interfere with you wearing a respirator? Yes No</b>	Yes	No
3. Have you <i>ever</i> had any of the following pulmonary or lung problems?		
a. Asbestosis:	Yes	No
b. Asthma: <b>If Yes, last episode date:</b> _____	Yes	No
c. Chronic bronchitis: <b>If Yes, last episode date:</b> _____	Yes	No
d. Emphysema: <b>If Yes, last episode date:</b> _____	Yes	No
e. Pneumonia: <b>If Yes, last episode date:</b> _____	Yes	No

f. Tuberculosis: : <b>If Yes, last episode date:</b> _____	Yes	No
g. Silicosis: : <b>If Yes, last episode date:</b> _____	Yes	No
h. Pneumothorax (collapsed lung): : <b>If Yes, last episode date:</b> _____	Yes	No
i. Lung cancer: : <b>If Yes, last episode date:</b> _____	Yes	No
j. Broken ribs: : <b>If Yes, last episode date:</b> _____	Yes	No
k. Any chest injuries or surgeries: : <b>If Yes, last episode date:</b> _____	Yes	No
l. Any other lung problems that you've been told about: : <b>If Yes, last episode date:</b> _____	Yes	No

<b>4. Do you currently have any of the following symptoms of pulmonary or lung illness?</b>		
a. Shortness of breath: <b>If Yes, is this an on-going problem? Yes No</b>	Yes	No
b. Currently have shortness of breath when walking fast on level ground or walking up a slight hill or incline:	Yes	No
c. Currently have Shortness of breath when walking with other people at a ordinary pace on level ground:	Yes	No
d. Currently have to stop for breath when walking at your own pace on level ground:	Yes	No
e. Current Shortness of breath when washing or dressing yourself:	Yes	No
f. Current Shortness of breath that interferes with your job:	Yes	No
g. Current or on-going coughing that produces phlegm (thick sputum):	Yes	No
h. Current or on-going coughing that wakes you early in the morning:	Yes	No
i. Current or on-going coughing that occurs mostly when you are lying down:	Yes	No
j. Current or on-going coughing up blood in the last month:	Yes	No
k. Current or on-going wheezing:	Yes	No
l. Current or on-going wheezing that interferes with your job:	Yes	No
m. Current or on-going chest pain when you breathe deeply:	Yes	No
n. Any other symptoms that you think may be related to lung problems or inability to wear a respirator:	Yes	No

<b>5. Have you ever had any of the following cardiovascular or heart problems?</b>		
a. Heart attack: If Yes, provide date: _____	Yes	No
b. Stroke: If Yes, provide date: _____	Yes	No
c. Angina: If Yes, provide date: _____	Yes	No
d. Heart failure: If Yes, provide date: _____	Yes	No
e. Swelling in your legs or feet (Not caused by walking): : If Yes, provide date: _____	Yes	No
f. Heart arrhythmia: (Heart beating irregularly) : If Yes, provide date: _____	Yes	No
g. High blood pressure: <b>If Yes, are you currently being treated by a Physician? Yes No</b>	Yes	No
h. Any other heart problem that you've been told about that may interfere with your ability to wear a respirator?	Yes	No

<b>6. Have you ever had any of the following cardiovascular or heart symptoms?</b>		
a. Frequent pain or tightness in your chest: <b>If Yes, is the problem current or on-going? Yes No</b>	Yes	No
b. Pain or tightness in your chest during physical activity: <b>If Yes, is the problem current or on-going? Yes No</b>	Yes	No
c. Pain or tightness in your chest that interferes with your job: <b>If Yes, is the problem current or on-going? Yes No</b>	Yes	No
d. In the past two years, have you Noticed your heart skipping or missing a beat: <b>If Yes, is the problem current or on-going? Yes No</b>	Yes	No
e. Heartburn or indigestion that is Not related to eating: <b>If Yes, is the problem current or on-going? Yes No</b>	Yes	No
f. Any other symptoms that you think may be related to heart or circulation problems: <b>If Yes, has this condition interfered with your ability to wear a respirator? Yes No</b>	Yes	No

<b>Part A Section 2. Mandatory (continued)</b>		
<b>7. Do you <i>currently</i> take medication for any of the following problems?</b>		
a. Breathing or lung problems:	Yes	No
b. Heart trouble:	Yes	No
c. Blood pressure:	Yes	No
d. Seizures (fits):	Yes	No
If Yes, to 7a through 7b above, have you had any problems wearing a respirator	Yes	No
<b>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):</b>	Yes	No
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 use of a respirator:	Yes	No
<b>9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?</b>	Yes	No

<b>Full Facepiece or SCBA:</b> Questions 10 to 15 below <b>must</b> be answered by every employee who has been selected to use either a full facepiece respirator or a self contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is <b>voluntary</b> .		
<b>10. Have you ever lost vision in either eye (temporarily or permanently)?</b>	Yes	No
<b>11. Do you <i>currently</i> have any of the following vision problems?</b>		
a. Wear contact lenses:	Yes	No
b. Wear glasses:	Yes	No
c. Color blind:	Yes	No
d. Any other eye or vision problems:	Yes	No
<b>12. Have you <i>ever</i> had an injury to your ears, including a broken eardrum?</b>	Yes	No
<b>13. Do you <i>currently</i> have any of the following hearing problems?</b>		
a. Difficulty hearing:	Yes	No
b. Wear a hearing aid:	Yes	No
c. Any other hearing or ear problem:	Yes	No
<b>14. Have you <i>ever</i> had a back injury?</b>	Yes	No
<b>15. Do you <i>currently</i> have any of the following musculoskeletal problems?</b>		
a. Weakness in any of your arms, hands, legs, or feet:	Yes	No
b. Back	Yes	No
c. Difficulty fully moving your arms and 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 side to side:	Yes	No
g. Difficulty bending at your knees	Yes	No
h. Difficulty squatting to the ground:	Yes	No
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.:	Yes	No
j. Any other muscle or skeletal problem that interferes with using a respirator:	Yes	No

**Please provide any current medical conditions or concerns:**

I have reviewed all of the above and have answered truthfully and to the best of my knowledge.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date