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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:

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

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, (see below) No**
 (Contact: Taylor Made Diagnostics at 757-494-1688)

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)
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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:

How many hours, per day do you wear a respirator? _____

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 ever had any of the following conditions?		
a. Seizures (fits): If Yes, last episode date: _____	Yes	No
b. Diabetes (sugar disease): If Yes, is your Diabetes being monitored by a physician? Yes No	Yes	No
c. Allergic reactions that interfere with your breathing: If Yes, last episode date: _____	Yes	No
d. Claustrophobia (fear of closed in places):	Yes	No
If Yes, any problems wearing a respirator? Yes No. If Yes, please explain		
e. Trouble smelling odors: If Yes, does it interfere with you wearing a respirator? Yes No	Yes	No
3. Have you ever had any of the following pulmonary or lung problems?		
a. Asbestosis:	Yes	No
b. Asthma: If Yes, last episode date: _____	Yes	No
c. Chronic bronchitis: If Yes, last episode date: _____	Yes	No
d. Emphysema: If Yes, last episode date: _____	Yes	No
e. Pneumonia: If Yes, last episode date: _____	Yes	No

f. Tuberculosis: : If Yes, last episode date: _____	Yes	No
g. Silicosis: : If Yes, last episode date: _____	Yes	No
h. Pneumothorax (collapsed lung): : If Yes, last episode date: _____	Yes	No
i. Lung cancer: : If Yes, last episode date: _____	Yes	No
j. Broken ribs: : If Yes, last episode date: _____	Yes	No
k. Any chest injuries or surgeries: : If Yes, last episode date: _____	Yes	No
l. Any other lung problems that you've been told about: : If Yes, last episode date: _____	Yes	No
4. Do you currently have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath: If Yes, is this an on-going problem? Yes No	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
5. Have you ever had any of the following cardiovascular or heart problems?		
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: If Yes, are you currently being treated by a Physician? Yes No	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
6. Have you ever had any of the following cardiovascular or heart symptoms?		
a. Frequent pain or tightness in your chest: If Yes, is the problem current or on-going? Yes No	Yes	No
b. Pain or tightness in your chest during physical activity: If Yes, is the problem current or on-going? Yes No	Yes	No
c. Pain or tightness in your chest that interferes with your job: If Yes, is the problem current or on-going? Yes No	Yes	No
d. In the past two years, have you Noticed your heart skipping or missing a beat: If Yes, is the problem current or on-going? Yes No	Yes	No
e. Heartburn or indigestion that is Not related to eating: If Yes, is the problem current or on-going? Yes No	Yes	No
f. Any other symptoms that you think may be related to heart or circulation problems: If Yes, has this condition interfered with your ability to wear a respirator? Yes No	Yes	No
Part A Section 2. Mandatory (continued)		
7. Do you currently take medication for any 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

8. If you've used a respirator, have you ever had any of the following problems?		
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
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	Yes	No

Full Facepiece or SCBA: Questions 10 to 15 below must 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 voluntary .		
10. Have you ever lost vision in either eye (temporarily or permanently)?	Yes	No
11. Do you <i>currently</i> have any of the following vision problems?		
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
12. Have you <i>ever</i> had an injury to your ears, including a broken eardrum?	Yes	No
13. Do you <i>currently</i> have any of the following hearing problems?		
a. Difficulty hearing:	Yes	No
b. Wear a hearing aid:	Yes	No
c. Any other hearing or ear problem:	Yes	No
14. Have you <i>ever</i> had a back injury?	Yes	No
15. Do you <i>currently</i> have any of the following musculoskeletal problems?		
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

If known, please provide month/date of last respirator review? _____

Have there been any medical changes since your last respirator questionnaire review? Yes / No If yes, please provide detail:

Please provide any current medical conditions, concerns or any new medications since your last respirator review:

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

Patient Signature

Date

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen?	Yes	No
If “Yes,” do you have feelings of dizziness, shortness of breath, pounding in you chest or other symptoms when you’re working under these conditions?	Yes	No

2. 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 you know them:		

3. Have you ever worked with any of the materials, or under any of the conditions listed below?		
a. Asbestos:	Yes	No
b. Silica (e.g. in sandblasting):	Yes	No
c. Tungsten/cobalt (e.g. grinding or welding this material):	Yes	No
d. Beryllium:	Yes	No
e. Aluminum:	Yes	No
f. Coal (for example, mining):	Yes	No
g. Iron:	Yes	No
h. Tin:	Yes	No
i. Dusty environments:	Yes	No
j. Any other hazardous exposures:	Yes	No
If “yes,” describe these exposures:		

4. List any second jobs or side businesses you have:

5. List your pervious occupations:

6. List your current and previous hobbies:

7. Have you been in the military services?	Yes	No
If “yes,” were you exposed to biological or chemical agents (either in training or combat):	Yes	No

8. Have you ever worked on a HAZMAT team?	Yes	No
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Part B (continued)

16. Describe the work you'll be doing while you're using your respirator(s)

17. Describe any special or hazardous conditions you might encounter when you're using your respirator (s) for example, confined spaces, life threatening gases)

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of toxic substance	Estimated maximum exposure level per shift	Duration of exposure per shift

19. Describe any special responsibilities you'll have while using your respirators(s) that may affect the safety and well being of others (for example, rescue, security):

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

Patient Signature

Date