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Respirator Medical Evaluation Questionnaire

To the employee: Can you read (circle one): Yes No

Today's date: _____
Name: _____ **Job Title**: _____
Your age (to nearest year): _____ **Sex** (circle one): Male Female
Height: _____ ft. _____ in. **Weight**: _____ lbs.
Email (required for online registry): _____
Phone number where you can be reached (include the Area Code): (_____) _____
The best time to phone you at this number:

Has your employer told you how to contact the health care professional who will review this questionnaire : Yes No

Check the type of respirator you will use (you can check more than one category):
___ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
___ Other type (ex, half- or full-facepiece type, PAPR, supplied-air, SCBA**).**

Have you worn a respirator (circle one): Yes No
If "yes," what type(s):

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month: Yes No
If Yes, how many cigarettes per day do you smoke?_____
How many years have you been smoking?_____

2. Have you ever had any of the following conditions?

Seizures (fits): Yes No
If Yes, list year you were diagnosed_____
Are you still experiencing any difficulties because of this condition?_____
If yes, please explain _____

Diabetes (sugar disease): Yes No
If Yes, list year you were diagnosed_____
Are you still experiencing any difficulties because of this condition?_____
If yes, please explain _____

Allergic reactions that interfere with your breathing: Yes No
Claustrophobia (fear of closed-in places) Yes No
Trouble smelling odors: Yes No

3. Have you ever had any of the following pulmonary or lung problems?

Asbestosis:	Yes	No	Silicosis:	Yes	No
Asthma:	Yes	No	Pneumothorax (collapsed lung):	Yes	No
Chronic bronchitis:	Yes	No	Lung cancer:	Yes	No
Emphysema:	Yes	No	Broken ribs:	Yes	No
Pneumonia:	Yes	No	Any chest injuries or surgeries:	Yes	No
Tuberculosis:	Yes	No	Any other lung problem that you've been told about:	Yes	No

If Yes, to any condition above, list the condition and year you were diagnosed:
Condition:_____ Year:_____
Are you still experiencing any difficulties because of this condition?_____
If yes, please explain _____

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

Shortness of breath:	Yes	No	Shortness of breath when washing or dressing yourself:	Yes	No
Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	Yes	No	Shortness of breath that interferes with your job:	Yes	No
Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes	No	Coughing that produces phlegm (thick sputum):	Yes	No
Have to stop for breath when walking at your own pace on level ground:	Yes	No	Coughing that wakes you early in the morning:	Yes	No
			Coughing that occurs mostly when you are lying down:	Yes	No

Coughing up blood in the last month:	Yes	No	Chest pain when you breathe deeply:	Yes	No
Wheezing:	Yes	No	Any other symptoms that you think		
Wheezing that interferes with your job:	Yes	No	may be related to lung problems:	Yes	No

Have you seen a physician for any of the above pulmonary/lung conditions? Yes No
If Yes, when did you last see the physician?_____

5. Have you ever had any of the following cardiovascular or heart problems?

Heart attack	Yes	No	Heart arrhythmia (heart beating irregularly):	Yes	No
Stroke:	Yes	No	High blood pressure:	Yes	No
Angina:	Yes	No	Any other heart problem that you've been		
Heart failure:	Yes	No	told about:	Yes	No
Swelling in your legs or feet					
(not caused by walking):	Yes	No			

If Yes, to any condition above, list the condition and year you were diagnosed:
Condition:_____ Year:_____
Are you still experiencing any difficulties because of this condition?_____
If yes, please explain _____

6. Have you ever had any of the following cardiovascular or heart symptoms?

Frequent pain or tightness in your chest:	Yes	No	In the past two years, have you noticed your heart		
Pain or tightness in your chest during			skipping or missing a beat:	Yes	No
physical activity:	Yes	No	Heartburn or indigestion that is not related		
Pain or tightness in your chest that interferes			to eating:	Yes	No
with your job:	Yes	No	Any other symptoms that you think may be		
			related to heart or circulation problems:	Yes	No

Have you seen a physician for any of the above cardiovascular or heart symptoms? Yes No
If Yes, when did you last see the physician?_____

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

Breathing or lung problems:	Yes	No	Blood pressure:	Yes	No
Heart trouble:	Yes	No	Seizures (fits):	Yes	No

If yes, to any of the above, please complete the following:
Medications:_____
How often taken:_____
Last time medication was taken:_____

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:)

Eye irritation:	Yes	No	Anxiety:	Yes	No
Skin allergies or rashes:	Yes	No	General weakness or fatigue:	Yes	No
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

Questions 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 currently have any of the following vision problems?

Wear contact lenses:	Yes	No	Color blind:	Yes	No
Wear glasses:	Yes	No	Any other eye or vision problem:	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 problems?

Difficulty hearing:	Yes	No	Wear a hearing aid:	Yes	No

Any other hearing or ear problem: Yes No

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

15. Do you currently have any of the following musculoskeletal problems?

Weakness in any of your arms, hands, legs, or feet: Yes No
Back pain: Yes No
Difficulty fully moving your arms and legs: Yes No
Pain or stiffness when you lean forward or backward at the waist: Yes No
Difficulty fully moving your head up or down: Yes No
Difficulty fully moving your head side to side: Yes No
Difficulty bending at your knees: Yes No
Difficulty squatting to the ground: Yes No
Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes No
Any other muscle or skeletal problem that interferes with using a respirator: Yes No

16. 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 your chest, or other symptoms when you're working under these conditions: Yes No

17. 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:

18. Have you ever worked with any of the materials, or under any of the conditions, listed below:

Asbestos: Yes No
Silica (e.g., in sandblasting): Yes No
Tungsten/cobalt (e.g., grinding or welding this material): Yes No
Beryllium: Yes No
Any other hazardous exposures: Yes No
If "yes," describe these exposures:

Aluminum: Yes No
Coal (for example, mining): Yes No
Iron: Yes No
Tin: Yes No
Dusty environments: Yes No

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

20. List your previous occupations:

21. List your current and previous hobbies:

22. 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

23. Have you ever worked on a HAZMAT team? Yes No

24. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes No

If "yes," name the medications if you know them:

25. Will you be using any of the following items with your respirator(s)?

HEPA Filters: Yes No
Canisters (for example, gas masks): Yes No
Cartridges: Yes No

26. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:

Escape only (no rescue):	Yes	No	Less than 2 hours per day:	Yes	No
Emergency rescue only:	Yes	No	2 to 4 hours per day:	Yes	No
Less than 5 hours per week:	Yes	No	Over 4 hours per day:	Yes	No

27. During the period you are using the respirator(s), is your work effort:

a. Light (less than 200 kcal per hour): Yes No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.

b. Moderate (200 to 350 kcal per hour): Yes No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

c. Heavy (above 350 kcal per hour): Yes No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

28. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes No

If "yes," describe this protective clothing and/or equipment:

29. Will you be working under cold conditions (temperature below 50 deg. F): Yes No

30. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes No

31. Will you be working under humid conditions: Yes No

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

33. Will you be working under the special or hazardous conditions you might encounter when you're using your respirator (s)?

- **a. Confined-spaced: Yes No**
- **b. Hyperbaric: Yes No**
- **c. Toxic substances: Yes No**

Describe any special or hazardous conditions list above:_____

34. 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 the first toxic substance:
Estimated maximum exposure level per shift:
Duration of exposure per shift

Name of the second toxic substance:
Estimated maximum exposure level per shift:
Duration of exposure per shift:

Name of the third toxic substance:
Estimated maximum exposure level per shift:
Duration of exposure per shift:

The name of any other toxic substances that you'll be exposed to while using your respirator:

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

Employee Signature	Date	PLHCP Signature	Date