MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
Respiratory Protection Evaluation Questionnaire with Medical Clearance (Initial)

OTSG APPROVED *(Date)* *(YYYYMMDD)*

Age _____ Gender: Male ____ Female ____ Height: _____ inches Weight: _____ pounds BP _____ / _____ P _____

Type of Respirator you will wear: PAPR ____ SCBA ____ N-95 to N-100 ____ Half-face ____ Full-Face ____ M-40 ____
Supplied Air ____ Other ____ If other, please specify: ______________________

Have you ever worn a respirator? Yes ____ NO ____ If yes, what type? _____________________________
Have you had problems wearing a respirator? Yes ____ NO ____ If yes, please explain: _____________________________

1. Do you currently smoke or have you smoked in the past month? Yes / NO

2. Have you ever had any of the following conditions?
   a. Seizures Yes / NO   c. Allergic reactions that interfere with your breathing Yes / NO   e. Trouble smelling odors Yes / NO
   b. Diabetes Yes / NO   d. Claustrophobia Yes / NO   f. High cholesterol Yes / NO

3. Have you ever had any of the following pulmonary or lung-problems?
   a. Asbestosis Yes / NO   g. Silicosis Yes / NO
   b. Asthma Yes / NO   h. Pneumothorax Yes / NO
   c. Emphysema Yes / NO   i. Lung cancer Yes / NO
   d. Pneumonia Yes / NO   j. Broken ribs Yes / NO
   e. Tuberculosis Yes / NO   k. Any chest injury or surgery Yes / NO
   f. Chronic Bronchitis Yes / NO

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of-breath Yes / NO
   b. Cough that produces phlegm Yes / NO
   c. Cough that occurs mostly when you are lying down Yes / NO
   d. Cough that wakes you early in the morning Yes / NO
   e. Coughing up blood in the last month Yes / NO
   f. Chest pain when you breathe deeply Yes / NO
   g. Shortness of breath when walking Yes / NO If yes, does it interfere with your job? Yes / NO
   h. Wheezing Yes / NO If yes, does it interfere with your job? Yes / NO
   i. Any other symptoms that you think may be related to lung problems Yes / NO

5. Have you ever had any of the following cardiovascular heart symptoms?
   a. Heart attack Yes / NO   d. Heart failure Yes / NO   g. Any other heart problem or condition Yes / NO
   b. Stroke Yes / NO   e. Heart arrhythmia Yes / NO
   c. Angina Yes / NO   f. High blood pressure Yes / NO

6. Have you ever had any of the following cardiovascular heart symptoms?
   a. Chest tightness/pain Yes / NO   d. Heartburn or indigestion Yes / NO
   b. Chest pain/tightness when working Yes / NO   e. Any other heart related symptoms Yes / NO
   c. Heart skipping or missing beats Yes / NO

7. Do you currently take medication for any of the following problems?
   a. Breathing or lung problems Yes / NO   c. Blood pressure Yes / NO
   b. Heart trouble Yes / NO   d. Seizures Yes / NO

8. If you have wore a respirator, have you ever had any of the following problems?
   a. Eye irritation Yes / NO   c. Anxiety Yes / NO
   b. Skin allergies Yes / NO   d. General weakness or fatigue Yes / NO

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE *(YYYYMMDD)*
Occupational Health Staff	MEDDAC-PMD-OH	

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)*

NAME:
SSN:
DOB:
MOS:
Job Title: Worksite Location:
Rank/Grade: Duty Phone:

☒ HISTORY/PHYSICAL ☐ FLOW CHART
☐ ☐ OTHER *(Specify)*
OTHER EXAMINATION OR EVALUATION
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

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Respiratory Protection Evaluation Questionnaire with Medical Clearance (Initial)	

9. Have you ever Lost vision in either eye, temporarily or permanently? Yes / NO

10. Do you currently have any of the following vision concerns or problems?
    a. Wear contact lenses Yes / NO
    b. Wear glasses Yes / NO
    c. Color blind Yes / NO
    d. Any other eye or vision problem Yes / NO

11. Have you ever had and injury to -your ears, including a perforated ear drum? Yes / NO

12. Do you currently have any of the following hearing problems?
    a. Difficulty hearing or hearing loss Yes / NO
    b. Wear a hearing aid Yes / NO
    c. Any other hearing or earproblem Yes / NO If yes, please describe: ____

13. Have you ever had a back injury? Yes / NO

14. Do you currently have any of the following musculoskelatal conditions or problems?
    a. Back pain or severe stiffness Yes / NO
    b. Weakness in arms, hands, legs, feet Yes / NO
    c. Difficulty moving your arms or legs Yes / NO
    d. Difficulty moving head up- &. down Yes / NO
    e. Difficulty moving head side, to side Yes / NO
    g. Difficulty bending your knees Yes / NO
    h. Difficulty squatting Yes / NO
    i. Difficulty bending over Yes / NO
    j. Difficulty climbing stair/ladder Yes / NO
    k. Difficulty carrying more than 20 lbs. Yes / NO

15. Would you like to talk with a physician who will review this questionnaire and your responses with you? Yes / NO

Employee Verification/Consent Statement

I verify that the above information is true and complete to the best of my knowledge. I hereby give permission for a physical examination (if needed) to determine my suitability for using a respirator. I understand that this examination is designed to satisfy regulatory requirements and should not be considered to be a routine medical examination. I agree to "self report " to my supervisor any changes in my medical condition that may affect my ability to work safely.

Full Name (print): ___________________________________ Signature: _____________________________ Date: _____________

Reviewing staff signature: ___________________________________ Date: _____________

Rx

OTC

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	*DATE (YYYYMMDD)*
Occupational Health Staff	MEDDAC-PMD-OH	

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)*

NAME:
SSN:
DOB:
MOS:
Job Title: Worksite Location:
Rank/Grade: Duty Phone:

OTHER EXAMINATION OR EVALUATION

☒ HISTORY/PHYSICAL
☐ FLOW CHART
☐
☐ OTHER *(Specify)*
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

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REPORT TITLE	OTSG APPROVED *(Date)* *(YYYYMMDD)*
Medical Opinion for Respiratory Fitness Evaluation	

RESULTS OF MEDICAL EVALUATION

____ Medical evaluation has detected no medical conditions that would prevent you from using a respirator.

____ Please note the following medical conditions that you should discuss with your personal primary care physician.

____ Hearing impairment that requires further evaluation. ____ See attached copy of the audiogram.

____ Impairment of visual acuity. ____ See attached copy of the vision screening tests.

____ Elevated BP. Your BP is _____ / _____.

____ Abnormal EKG. ____ See attached copy of your EKG.

____ Abnormal PFT. ____ See attached copy of your pulmonary function test.

____ Other: ____

____ Please provide us medical information regarding: ____

RESPIRATOR USE RECOMMENDATIONS

____ No restrictions on respiratory use. ____ May proceed with fit test. ____ Observe for claustrophobia during fit test.

____ Restrictions on respirator use required: ____

____ DO NOT PROCEED with FIT TEST.

____ No respirator use permitted. ____ Temporary ____ Permanent

______________________________ ________________________________ _________________

Physician/PLHCP Stamp Signature Date

____

FIT TEST RESULTS

Fit Test Date: _________________________

Respirator: Brand: __________ Model: ______________ Type: ___ Half-Mask ___ Full-Face Disposable: ___ Yes ___ No

____ Pass ____ Fail

______________________________ ________________________________ _________________

Fit Test Operator Stamp Signature Date

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	*DATE (YYYYMMDD)*
Occupational Health Staff	MEDDAC-PMD-OH	

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)*

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OTHER EXAMINATION OR EVALUATION

Worksite Location:
Duty Phone:

- ☒ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT