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RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Part A

To the employer:_____ Answers to questions in Section 1 and to question 9 in Section 2 of Part A, do not require a medical examination.

To the Employee, Patient ID:_____ 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. Your employer must tell you how to send or deliver this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) Every employee selected to use any type of respirator must provide the following information (please print).

1. Date:_____
2. Name:_____
3. Age: _____
4. Sex: ☐Male ☐Female
5. Height: _____
6. Weight:_____
7. Your job title:_____
8. A phone number where the health care professional can reach you (include the Area Code):

   _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire (check one)? ☐Yes ☐No
11. Check the type of respirator you will use (you can check 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 type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator (check one)? ☐Yes ☐No

    If "yes," what type(s)?_____

Part A. Section 2. (Mandatory) Every employee selected to use any type of respirator must answer questions 1 through 9 below (please check "yes" or "no").

1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month? ☐Yes ☐No
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

3. Have you *ever had* any of the following pulmonary or lung problems?
   a. Asbestosis ☐Yes ☐No
   b. Silicosis ☐Yes ☐No
   c. Asthma ☐Yes ☐No
   d. Pneumothorax (collapsed lung) ☐Yes ☐No
   e. Chronic bronchitis ☐Yes ☐No
   f. Lung cancer ☐Yes ☐No
   g. Emphysema ☐Yes ☐No
   h. Broken ribs ☐Yes ☐No
   i. Pneumonia ☐Yes ☐No
   j. Any chest injuries or surgeries ☐Yes ☐No
   k. Tuberculosis ☐Yes ☐No
   l. Any other lung problem that you have 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 in the last month ☐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. Stroke ☐Yes ☐No
   c. Angina ☐Yes ☐No
   d. Heart failure ☐Yes ☐No
   e. Swelling in your legs or feet (not caused by walking) ☐Yes ☐No
   f. Heart arrhythmia (heart beating irregularly) ☐Yes ☐No
   g. High blood pressure ☐Yes ☐No
   h. Any other heart problems that you have 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 2 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

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 have used a respirator, have you ever had any of the following problems? (If you have never used a respirator continue to question 9)
   a. Eye irritation..... ☐Yes ☐No
   b. Skin allergies or rashes ..... ☐Yes ☐No
   c. Anxiety..... ☐Yes ☐No
   d. General weakness of fatigue ..... ☐Yes ☐No
   e. Any other problem that interferes with your use of a respirator ..... ☐Yes ☐No

9. Would you like to discuss your answers with the health care professional who will review this questionnaire? ..... ☐Yes ☐No

Questions 10 to 15 must be answered if you will use either a full-face respirator or a self-contained breathing apparatus (SCBA).

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?
   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

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?
   a. Difficulty hearing ..... ☐Yes ☐No
   b. Wear a hearing aid ..... ☐Yes ☐No
   c. 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?
   a. Weakness in any of your arms, hands, legs, or feet..... ☐Yes ☐No
   b. Back pain..... ☐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 pounds ..... ☐Yes ☐No
   j. Any other muscle or skeletal problem that interferes with using a respirator..... ☐Yes ☐No

Examiner Comments:

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Part B – Discretionary Questions

Name:_____ Date:_____

Patient ID:_____

Your job title:_____

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 your chest, or other symptoms when you are working under these condition? ☐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. Coal (for example, mining) ☐Yes ☐No
   c. Silica (e.g., sandblasting) ☐Yes ☐No
   d. Iron ☐Yes ☐No
   e. Tungsten/cobalt (grinding or welding this material) ☐Yes ☐No
   f. Tin ☐Yes ☐No
   g. Dusty environments ☐Yes ☐No
   h. Beryllium ☐Yes ☐No
   i. Any other hazardous exposures ☐Yes ☐No
   j. Aluminum ☐Yes ☐No

   If "yes," describe these exposures:

   _____

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

   _____

5. List your previous occupations:

   _____

6. List your current and previous hobbies:

   _____

7. Were you ever 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

9. 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:

   _____

10. Will you be using any of the following items with your respirator(s)?
    a. HEPA filters ☐Yes ☐No
    b. Canisters (i.e., gas masks) ☐Yes ☐No
    c. Cartridges ☐Yes ☐No

11. How often will you be using the respirator(s)? (Mark "yes" or "no" for all answers that apply.)
    a. Escape only (no rescue) ☐Yes ☐No
    b. Less than 2 hrs. per day ☐Yes ☐No
    c. Emergency rescue only ☐Yes ☐No
    d. 2 to 4 hrs. per day ☐Yes ☐No
    e. Less than 5 hrs. per week ☐Yes ☐No
    f. over 4 hrs. per day ☐Yes ☐No

12. When 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 light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while 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, drilling, nailing performing assembly work, or transferring a moderate load (about 35 pounds) 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 pounds) 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 pounds) 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 pounds).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when using your respirator? ☐Yes ☐No

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

    _____

14. Will you be working in hot conditions (temperature more than 77 degrees F)? ☐Yes ☐No
15. Will you be working in humid conditions? ☐Yes ☐No

16. Describe the work you will be doing while using your respirator(s):

_____

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

_____

18. Provide the following information, if you know it, for each toxic substance that you will be exposed to when 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: _____

Name of any other toxic substances that you will be exposed to while using a respirator:

_____

19. Describe any special responsibilities you will have while using their respirator(s) that may affect the safety and well-being of others (i.e., rescue, security):

_____