LOURDES

Respirator Medical Evaluation Questionnaire-Part A

Occupational Health Services
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The information provided is CONFIDENTIAL.

The following information must be provided by every employee who has been selected to use any type of respirator **(please print).**

1. Your name: _____2. Date of birth:_____
3. Sex (circle one): Male/Female 4. Height: _____ft. _____ in. 5. Your weight: _____lbs.
6. Your job title: _____7. Company/Department_____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire:
(daytime)_____ (evening) _____

9. 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-facepiece type, powered-air purifying, supplied-air, self contained breathing apparatus) _____

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

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").

If you answer yes to any question, please provide date of diagnosis, duration, list of medications or last episode in the comment section at the end of this questionnaire.

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. Asthma: Yes/No
   c. Chronic bronchitis: Yes/No
   d. Emphysema: Yes/No
   e. Pneumonia: Yes/No
   f. Tuberculosis: Yes/No
   g. Silicosis: Yes/No
   h. Pneumothorax (collapsed lung): Yes/No
   i. Lung cancer: Yes/No
   j. Broken ribs: Yes/No
   k. Any chest injuries or surgeries: Yes/No
   l. Any other lung problem that you've been told about: Yes/No

OHS use only

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Name: _____ DOB: _____ Date: _____

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

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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 problem that you've 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 two 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'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

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Name: _____ DOB: _____ Date: _____

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

Comments:

_____

_____

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.

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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 lbs: Yes/No
    j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

Signature: _____ Date: _____

Reviewed by: _____Date:_____

Cleared□

Follow-up required□_____

For clinician use only: Part B completed? Yes/No