READING HOSPITAL
OCCUPATIONAL HEALTH SERVICES

MEDICAL RESPIRATOR QUESTIONNAIRE
SHORT FORM

To be used after full form has been completed and is on file.

Name: ______________________ **Social Security Number:** ______________ **Date Of Birth:** __________

Company Name: ______________________ **Date:** ______________

IN THE LAST YEAR HAS A DOCTOR TOLD YOU THAT YOU HAVE HAD?

	YES	NO
1. Angina		
2. Heart Attack		
3. Heart Disease		
4. Epilepsy or Seizures		
5. High Blood Pressure		
6. Diabetes Treated with Insulin		
7. Lung Disease		
8. Emphysema		
9. Asthma		

IN THE LAST YEAR HAVE YOU:

	YES	NO
10. Had significant weight loss?		
11. Had a change in facial features that could impact your ability to use a respirator?		
12. Had any problems with wearing the respirator?		
13. Experienced shortness of breath?		
14. Experienced chest pain?		
15. Taken any medications?		
16. Changed your smoking habits?		

Please explain any YES answers by number:

For OHS Provider Use only

Approved Not Approved More information needed

Healthcare Provider Signature: ______________________ **Date:** ____________