Respirator Medical Evaluation Questionnaire

Name: ______________________ Social Security #: ______________________ Age in years: ______ Date: __________

Employer: ______________________ Job Title: ______________________ Sex (check one) ❐ Male ❐ Female

Have you ever worn a respirator: ❐ Yes ❐ No If "yes," what type: ______________________

Your Height: __________ Your Weight: __________

Every employee who has been 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
   - c. Trouble smelling odor (not related to having a cold): ❐ 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. Pneumthorax (cllapsed 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 have been told about: ❐ Yes ❐ No

4. Do you currently have any of the folowing symptoms of pulmonary or lung illness?
   - a. Shortness of breath: ❐ Yes ❐ No
   - b. Shortness of breath when walking fast on ground level 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 within 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 might be related to lung problems: ❐ Yes ❐ No

(please turn over)

Respirator Medical Evaluation Questionnaire (2)

5. Have you ever had any of the following cardiovascular or heart problems?
   - a. Heart attack: ☐ Yes ☐ No
   - b. Swelling in your legs or feet (not caused by walking): ☐ Yes ☐ No
   - c. Stroke: ☐ Yes ☐ No
   - d. Heart arrhythmia (heart beating irregularly): ☐ Yes ☐ No
   - e. Angina: ☐ Yes ☐ No
   - f. High blood pressure: ☐ Yes ☐ No
   - g. Heart failure: ☐ Yes ☐ No
   - h. Any other heart problem: ☐ Yes ☐ No

6. Have you ever had any of the following cardiovascular or heart symptoms?
   - a. Frequent pain or tightness in chest: ☐ Yes ☐ No
   - b. Pain or tightness in chest during physical activity: ☐ Yes ☐ No
   - c. Pain or tightness in 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 use 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: ☐
   - a. Eye irritation: ☐ Yes ☐ No
   - b. Skin allergy or rashes: ☐ Yes ☐ No
   - c. Anxiety (related to the respirator): ☐ Yes ☐ No
   - d. General weakness or fatigue: ☐ Yes ☐ No
   - e. Any other problems that interferes with your use of the 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 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece 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?
    - a. Wear contact lenses: ☐ Yes ☐ No
    - b. Wear glasses: ☐ Yes ☐ No
    - c. Color blind: ☐ Yes ☐ No
    - d. Any other eye or vision problems: ☐ 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 problems: ☐ 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 knee: ☐ 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 muscular or skeletal problem that interferes with using a respirator: ☐ Yes ☐ No