WORK PARTNERS
OCCUPATIONAL HEALTH SPECIALISTS

Respirator Medical Evaluation Questionnaire

Part A, Section 1 and 2 (for full-face and SCBA respirators), Part B

To the employee:

This questionnaire is only to be distributed to and completed by individuals who are proficient in reading and writing English.

Your supervisor must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. Your supervisor is not permitted to look at or review your answers. To maintain your confidentiality, please send your responses directly to the licensed health care professional listed below.

This evaluation is **mandatory** to help determine your ability to wear a respirator. Your answers will remain confidential. After a review of your responses, the licensed health care professional may in some cases recommend that you receive a physical exam to complete your evaluation. Once you have received medical clearance to wear a respirator, you and your supervisor will receive notification of your approval to be fitted for a respirator.

PART A. SECTION 1. (*please print*)

Today's Date: _____ Company: _____

Last Name: _____ First Name: _____ Social Security #: _____

Mailing Address: _____ Zip Code: _____

Your Age: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Your Height: _____ ft._____ in. Your Weight: _____ lbs.

Your Job Title: _____

A phone number where you can be reached by the health care professional who reviews this questionnaire:

_____ The best time to phone you at this number: _____

Your e-mail address: _____

Has your employer told you how to contact the health care professional who will review this questionnaire (check one): _____ Yes ☐ No ☐

Check the type of respirator you will use (you can check more than one category):

☐ N, R, or P disposable respirator (filter-mask, non- cartridge type only).

☐ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Have you worn a respirator (circle one): _____ Yes ☐ No ☐

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

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PART A. SECTION 2. (MANDATORY)

1. Do you **CURRENTLY** smoke tobacco, or have you smoked tobacco in the last month?… ☐ No ☐ Yes
   - If YES, how many cigarettes per day do you smoke? ____
   - How many years have you been smoking? _____

2. Have you ever had any of the following conditions?
   a. Seizures (fits)…….. ☐ No ☐ Yes
      - If **YES**, list the year you were diagnosed: _____
      - Are you still experiencing any difficulties because of this condition? ☐ No ☐ Yes
      - If **YES**, please explain:
        _____
   b. Diabetes (sugar disease)…….. ☐ No ☐ Yes
      - If **YES**, list the year you were diagnosed: _____
      - Are you still experiencing any difficulties because of this condition? ☐ No ☐ Yes
      - If **YES**, please explain:
        _____
   c. Allergic reactions that interfere with your breathing…….. ☐ No ☐ Yes
   d. Claustrophobia (fear of closed-in places)…… ☐ No ☐ Yes
   e. Trouble smelling odors…….. ☐ No ☐ Yes

3. Have you ever had any of the following pulmonary or lung problems?
   a. Asbestosis …… ☐ No ☐ Yes
   b. Asthma…….. ☐ No ☐ Yes
   c. Chronic bronchitis…… ☐ No ☐ Yes
   d. Emphysema ……. ☐ No ☐ Yes
   e. Pneumonia…….. ☐ No ☐ Yes
   f. Tuberculosis…….. ☐ No ☐ Yes
   g. Silicosis…….. ☐ No ☐ Yes
   h. Pneumothorax (collapsed lung) …….. ☐ No ☐ Yes
   i. Lung cancer ……. ☐ No ☐ Yes
   j. Broken ribs ……. ☐ No ☐ Yes
   k. Any chest injuries or surgeries …… ☐ No ☐ Yes
   l. Any other lung problem that you've been told about …… ☐ No ☐ Yes

   - If **YES** to any condition above, list the condition and year you were diagnosed:
     CONDITION_____ YEAR__ _____
   - Are you still experiencing any difficulties because of this condition? ☐ No ☐ Yes
   - If **YES**, please explain: _____
     _____

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PART A. SECTION 2. CONTINUED (MANDATORY)

4. Do you **CURRENTLY** have any of the following symptoms of pulmonary or lung illness?

a.	Shortness of breath……	☐ No	☐ Yes
b.	Shortness of breath when walking fast on level ground or walking up a slight hill or incline ……	☐ No	☐ Yes
c.	Shortness of breath when walking with other people at an ordinary pace on level ground……..	☐ No	☐ Yes
d.	Have to stop for breath when walking at your own pace on level ground……..	☐ No	☐ Yes
e.	Shortness of breath when washing or dressing yourself……..	☐ No	☐ Yes
f.	Shortness of breath that interferes with your job……	☐ No	☐ Yes
g.	Coughing that produces phlegm (thick sputum) ……	☐ No	☐ Yes
h.	Coughing that wakes you early in the morning ……..	☐ No	☐ Yes
i.	Coughing that occurs mostly when you are lying down……	☐ No	☐ Yes
j.	Coughing up blood in the last month……	☐ No	☐ Yes
k.	Wheezing……..	☐ No	☐ Yes
l.	Wheezing that interferes with your job……..	☐ No	☐ Yes
m.	Chest pain when you breathe deeply ……...	☐ No	☐ Yes
n.	Any other symptoms that you think may be related to lung problems……	☐ No	☐ Yes

- Have you seen a physician for any of the above pulmonary/lung conditions? ☐ No ☐ Yes
- If **YES**, when did you last see the physician? _____

5. Have you **ever had** any of the following cardiovascular or heart problems?

a.	Heart attack……..	☐ No	☐ Yes
b.	Stroke……	☐ No	☐ Yes
c.	Angina ……..	☐ No	☐ Yes
d.	Heart failure ……	☐ No	☐ Yes
e.	Swelling in your legs or feet (not caused by walking)……	☐ No	☐ Yes
f.	Heart arrhythmia (heart beating irregularly)……	☐ No	☐ Yes
g.	High blood pressure……	☐ No	☐ Yes
h.	Any other heart problem that you've been told about……	☐ No	☐ Yes

- If **YES** to any condition above, list the condition and year you were diagnosed: CONDITION_____ YEAR__ _____
- Are you still experiencing any difficulties because of this condition? ☐ No ☐ Yes
- If **YES**, please explain: _____

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PART A. SECTION 2. CONTINUED (MANDATORY)

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

a.	Frequent pain or tightness in your chest ……	☐ No	☐ Yes
b.	Pain or tightness in your chest during physical activity……	☐ No	☐ Yes
c.	Pain or tightness in your chest that interferes with your job……	☐ No	☐ Yes
d.	In the past two years, have you noticed your heart skipping or missing a beat……	☐ No	☐ Yes
e.	Heartburn or indigestion that is not related to eating ……	☐ No	☐ Yes
f.	Any other symptoms that you think may be related to heart or circulation problems…...	☐ No	☐ Yes

- Have you seen a physician for any of the above cardiovascular/heart conditions? ☐ No ☐ Yes
- If **YES**, when did you last see the physician? _____

7. Do you **CURRENTLY** take medication for any of the following problems?

a.	Breathing or lung problems……	☐ No	☐ Yes
b.	Heart trouble ……	☐ No	☐ Yes
c.	Blood pressure……	☐ No	☐ Yes
d.	Seizures (fits)……...	☐ No	☐ Yes

If **YES** to any of the above, please complete the following:

- Medication(s): _____
- How often taken: _____
- Last time medication was taken: _____

8. If you've used a respirator, have you **ever had** any of the following problems?
(If you've never used a respirator, check the following box and go to question 9)……...☐

a.	Eye irritation ……	☐ No	☐ Yes
b.	Skin allergies or rashes ……	☐ No	☐ Yes
c.	Anxiety ……..	☐ No	☐ Yes
d.	General weakness or fatigue……	☐ No	☐ Yes
e.	Any other problem that interferes with your use of a respirator……...	☐ No	☐ Yes

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

Questions 10 through 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 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 or 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 the 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 ☐

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PART B. Any of the following questions and other questions not listed may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

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're working under these conditions? _____ Yes ☐ No ☐

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (i.e., 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. Silica (i.e., in sandblasting) Yes ☐ No ☐
   c. Tungsten/cobalt (i.e., grinding or welding this material) Yes ☐ No ☐
   d. Beryllium _____ Yes ☐ No ☐
   e. Aluminum _____ Yes ☐ No ☐
   f. Coal (I.e., mining) _____ Yes ☐ No ☐
   g. Iron _____ Yes ☐ No ☐
   h. Tin _____ Yes ☐ No ☐
   i. Dusty environments _____ Yes ☐ No ☐
   j. Any other hazardous exposures Yes ☐ No ☐

   If "Yes," describe these exposures: _____

4. List any second jobs or side business you have: _____
5. List your previous occupations: _____
6. List your current and previous hobbies: _____
7. Have you been 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 medications for any other 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?

    a. HEPA filters: _____ Yes ☐ No ☐
    b. Canisters (i.e., gas mask) ___ Yes ☐ No ☐
    c. Cartridges _____ Yes ☐ No ☐

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PART B CONTINUED

11. How often are you expected to use the respirator(s)? Answer for all answers that apply to you.

a.	Escape only (no rescue)	Yes ☐	No ☐	d.	Less than 2 hours per week	Yes ☐	No ☐
b.	Emergency rescue only	Yes ☐	No ☐	e.	2 to 4 hours per day	Yes ☐	No ☐
c.	Less than 5 hours per week	Yes ☐	No ☐	f.	Over 4 hours per day	Yes ☐	No ☐

12. During the period 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: _____ hours _____ minutes

Examples of light work effort are *sitting* while writing, typing, drafting, or performing light assembly work, or *standing* while operating a drill press (1 to 3 lbs.) or controlling machines.

b. *Moderate* (200 to 350 kcal per hour)? Yes ☐ No ☐

If "Yes," how long does this period last during the average shift: _____ hours _____ minutes

Examples of moderate work effort are *sitting* while nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) 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 lbs.) 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: _____ hours _____ minutes

Examples of heavy work are *lifting* a heavy load (about 50 lbs.) 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 lbs.).

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

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

14. Will you be working under hot conditions (temperature exceeding 77 deg. F) Yes ☐ No ☐

15. Will you be working under humid conditions: Yes ☐ No ☐

16. Describe the work you will be doing while you are using the respirator: _____

PART B CONTINUED

17. Describe any special or hazardous conditions you might encounter when you are using your respirator(s). i.e., 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 you are using your respirator(s):

(1) Name the first toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

(2) Name the second toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

(3) Name the third toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

The name of any other toxic substances that you will be exposed to while you are using the respirator: _____

_____

_____

_____

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

_____

_____

_____

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COMMENTS: EXPLAIN ANY "YES" ANSWERS NOT ALREADY DISCUSSED. DESCRIBE ANY SYMPTOMS OR CONDITIONS WHICH COULD INTERFERE WITH YOUR ABILITY TO USE A RESPIRATOR SAFELY AND EFFECTIVELY.

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_____

Please sign your name below indicating the answers you have provided are true and correct to the best of your knowledge.

_____ _____
Signature Date

CLINICIAN USE ONLY:

☐ Cleared to use a respirator. ☐ Not cleared to use a respirator.

Clinician Name: _____ Date: _____

Clinician Signature: _____