WORK PARTNERS
OCCUPATIONAL HEALTH SPECIALISTS

Respirator Medical Evaluation Questionnaire

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

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

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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.

_____

_____

_____

_____

_____

_____

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: _____