# RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

To the employer: Answer to questions in section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

**To the employee: Can you read? (Circle one) YES / NO**

Your employer must allow you to answer this questionnaire during normal working hours, or at a time that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

**Part A Section 1. Every employee who has been selected to use any type of respirator must provide the following information. (PLEASE PRINT)**

1.) Today's Date:____________________
2.) Your Name:____________________
3.) Your ID#:____________________
4.) Your Age (to nearest year):____________________
5.) Sex (circle one): Male / Female
6.) Your height: ________ft. ________inches
7.) Your weight: ________lbs.
8.) A phone number where you can be reached by the health care professional who reviews this questionnaire (including Area Code):____________________
9.) The best time to phone you at that number:____________________
10.) Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): ____________________YES / NO
11.) Check the type of respirator you will use (you can check more than one category):
a. _____N, R, P disposable respirator (filter-mask, non-cartridge type only.)
b. _____Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12.) Have you worn a respirator (Circle one): ____________________YES / NO
If "Yes", what type(s):____________________
13.) Your job title:____________________

**Part A Section 2. 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").**

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. Chronic Bronchitis:__________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

4.) Do you currently have any of the following symptoms of pulmonary or lung disease?

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: ____ 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 breath deeply: ____ YES / NO
n. Any other symptoms that you think may be related to lung problems: ____ YES / NO

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 exertion: ____ 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?
(If you've never used a respirator, check the following space and go to question 9.) ____

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

9.) Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: ____ YES / NO

Every employee who has been selected to use a full face piece or a self-contained breathing apparatus (SCBA) must answer questions 10 to 15 below. For employees who have been selected to use other types of respirators, answer these questions voluntarily.

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. Wearing a hearing aid: ________ YES / NO
c. Any other hearing 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 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 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