

Respirator Medical Evaluation Questionnaire

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Section A-Employee Information

Indicate type of respirator to be used:

- 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 – self contained breathing apparatus.)

Per OSHA Respirator Standards, if you have been selected to wear a respirator you must answer the following questions.

Date: _____ Can you read? Yes No

Last Name: _____ Middle Initial: _____ First Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security Number: _____ Age: _____

Male Female Height: _____ Weight: _____

Phone Number: _____ Best time to phone if necessary: _____

Employer: _____ Work Phone: _____

Your Job Title: _____

Has your employer told you how to contact the physician who will review this form? Yes No

Have you worn a respirator before? Yes No If yes, what type? _____

Section B – Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. 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 enclosed spaces)? ----- Yes No
 - e. Trouble smelling odors? ----- Yes No

3. Have you ever had any pulmonary or lung problems? ----- Yes No
If no, skip to question 4. If yes, please answer the following questions:
 - 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
 - l. Any other lung problem that you've been told about? ----- Yes No

4. Do you currently have any symptoms of pulmonary or lung illness? ----- Yes No
If no, skip to question 5. If yes, please answer the following questions:
 - a. Shortness of Breath? ----- Yes No
 - b. Shortness of breath when walking fast on level ground or when walking up a slight hill or incline? ----- Yes No
 - c. Shortness of breath when walking at your own 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 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 in 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 you think might be related to a lung problem? ----- 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 and feet (not caused by walking)? ----- Yes No
- f. Heart arrhythmia (irregular heartbeats)? ----- Yes No
- g. High blood pressure? ----- Yes No
- h. Any other heart problem 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 activity? ----- 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 not related to eating? ----- Yes No
- f. Any other symptom that you think may be related to heart or circulation problems? ----- Yes No
7. Do you currently take any medications for the following problems?
- a. Breathing or lung problems? ----- Yes No
- b. Heart trouble? ----- Yes No
- c. Blood pressure? ----- Yes No
- d. Seizures? ----- Yes No

8. If you have used a respirator, have you ever had any of the following problems? (If you've never used a respirator, skip to question 9.)
- a. Eye irritation? ----- Yes No
 - b. Skin allergies or rashes? ----- Yes No
 - c. Anxiety? ----- Yes No
 - d. General weakness and fatigue? ----- Yes No
 - e. Breathing difficulty? ----- Yes No
 - f. Any other problems that interfere with your use of a respirator? - Yes No
9. Would you like to speak with the health care professional who will review this questionnaire regarding any of your answers to this questionnaire? -- Yes No

Questions 10 through 15 below must be answered by every employee who has been selected to use either a full facepiece respirator or a self contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering the following 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 perforated 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 ear or hearing problem? ----- Yes No
14. Have you ever had a back injury? ----- Yes No

15. Do you currently have any musculoskeletal problems? ----- Yes No

If no, continue to the signature portion. If yes, please answer the following questions:

- a. Weakness in any part 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 when fully moving you head up and down? ----- Yes No
- f. Difficulty when fully moving your head side to side? ----- Yes No
- g. Difficulty when bending at your knees? ----- Yes No
- h. Difficulty when squatting to the ground? ----- Yes No
- i. Difficulty when climbing stairs or ladders and carrying more than 25 pounds? ----- Yes No
- j. Difficulty with any other muscle or skeletal problem that interferes with using a respirator? ----- Yes No

Please sign your name below indicating that the answers you have given on this questionnaire are true and correct to the best of your knowledge.

Signature

Date