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**RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE**

<b>COMPANY:</b>		<b>LOCATION:</b>	
<b>PATIENT:</b>		<b>ADDRESS:</b>	
<b>SSN:</b>	<b>DOB:</b>	<b>AGE:</b>	<b>SEX:    M    F</b>

**TO THE EMPLOYER**

Answer to questions in Section 1 and to question 9 in Section 2, do not require a medical examination. It does require a Physician or a Licensed Healthcare Professional review the questionnaire and answer any questions you may have concerning any questions asked in this questionnaire.

**TO THE EMPLOYEE**

Can you read?    Yes      No  

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

**TO THE PHYSICIAN OR OTHER LICENSED HEALTHCARE PROFESSIONAL**

Review Part A, Sections 1 and 2. When an employee answers YES to any of the questions in Section 2, and the questionnaire is not administered in conjunction with a physical examination, the employee needs to be considered for a follow-up physical examination with particular emphasis on those questions in which the employee answered YES.

When an employee answers YES to any of the questions in Section 2, and this questionnaire is completed in conjunction with a physical examination, the Physician will place particular emphasis upon those areas to which the employee answered YES. In either situation the Physician or Licensed Healthcare Professional will complete the PLCHP's Written Statement to both the employer and the employee within 2 days.

**PART A SECTION 1 (MANDATORY)**

**Every employee who had been selected to use any type of respirator or mask must provide the following information.**

**(Please Print)**

1. Your height: \_\_\_\_\_ ft. \_\_\_\_\_ in.
2. Your weight: \_\_\_\_\_ lbs.
3. Your job title: \_\_\_\_\_
4. A phone number where you can be reached by a Healthcare Professional who will review this questionnaire: (\_\_\_\_) \_\_\_\_\_
5. The best time to contact you at this number: \_\_\_\_\_ am \_\_\_\_\_ pm
6. Has your employer told you how to contact the Healthcare Professional who will be reviewing this questionnaire? Yes  No
7. Check the type of respirator you will use: (you can check more than one category)
  - a. \_\_\_\_\_ N, R, or P disposable respirator (filter mask, non-cartridge type only)
  - b. \_\_\_\_\_ Other type (half face, full face, powered air purified, supplied air, self containing breathing apparatus (SCBA))
8. Have you ever worn a respirator or mask? Yes  No  If Yes, what type(s): \_\_\_\_\_

**PART A SECTION 2 (MANDATORY)**

**Every employee who has been selected to use any type of respirator or mask must answer questions 1 – 9.**

1. **Do you currently smoke tobacco or have you smoked in the last month?** Yes  No
2. **Have you ever had or currently have any of the following conditions?**
  - a. Seizures Yes  No
  - b. Diabetes Yes  No
  - c. Allergic Reactions that interfere with your breathing Yes  No
  - d. Claustrophobia (fear of closed in spaces) Yes  No
  - e. Trouble smelling odors Yes  No
3. **Have you ever had or currently have any of the following 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
  - l. Any other lung problem that you have been told about Yes  No
4. **Do you currently have any of the following breathing issues?**
  - a. Shortness of breath Yes  No
  - b. Shortness of breath when walking on level ground or slight incline Yes  No
  - c. Shortness of breath when walking with other people at a normal 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 bathing 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 up in the mornings 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 that you think may be related to lung problems Yes  No

5. **Have you ever had any of the following 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 Yes  No
  - f. Heart arrhythmia Yes  No
  - g. High blood pressure Yes  No
  - h. Any other heart problems that you have been told about Yes  No
6. **Have you ever had any of the following 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 that is not related to eating Yes  No
  - f. Any other symptoms that you think might be related to heart or circulation problems Yes  No
7. **Do you currently take any medications 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 Yes  No
8. **If you have used a respirator or mask, have you ever had any of the following problems? If you have never used a respirator or mask, check Unknown.**
- a. Eye irritation Yes  No  Unknown
  - b. Skin allergies or rashes Yes  No  Unknown
  - c. Anxiety Yes  No  Unknown
  - d. General weakness or fatigue Yes  No  Unknown
  - e. Any other problems that interfere with your use of a respirator Yes  No  Unknown
9. **Would you like to speak to the Healthcare Professional who will review this questionnaire?** Yes  No

**PART A SECTION 2.1**  
**FULL FACE/SCBA (MANDATORY)**

Questions 10 to 15 below must be answered by every employee who has been selected to use either full face respirator/ mask or a self continued breathing apparatus (SCBA).

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 or vision correction?**
- a. Wear contacts 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 any injury to your ears, including a perforated eardrum?** Yes  No
13. **Do you currently have any of the following hearing problems?**
- a. Difficulty hearing Yes  No
  - b. Wear a hearing aide Yes  No
  - c. Any other hearing or ear problems Yes  No
14. **Have you ever had a back injury?** Yes  No
15. **Do you 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 <input type="checkbox"/> No <input type="checkbox"/> |
| g. Difficulty bending at your knees   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| h. Difficulty squatting to the ground   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| i. Climbing a flight of stairs or a ladder carrying more than 25 lbs            | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| j. Any other muscle or skeletal problem that interferes with using a respirator | Yes <input type="checkbox"/> No <input type="checkbox"/> |

**PHYSICIAN OR LICENSED HEALTHCARE PROFESSIONAL TO COMPLETE**

Check the **ONE** that applies

- ┌ I have reviewed Part A section 2 and section 2.1 of this questionnaire **with** the employee and **I do not recommend that a physical examination be performed at this time.**
- ┌ I have reviewed Part A section 2 and section 2.1 of this questionnaire **with** the employee and **I am recommending that a physical examination be performed at this time.**
- ┌ I have reviewed Part A section 2 and section 2.1 of this questionnaire **without** the employee and **I do not recommend that a physical examination be performed at this time.**
- ┌ I have reviewed Part A section 2 and section 2.1 of this questionnaire **without** the employee and **I am recommending that a physical examination be performed at this time.**

\_\_\_\_\_  
PLHCP Signature

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date