T K Group, Inc
15340 Vantage Pkwy East, Suite 220
Houston, Texas 77032
Office: 713.280.0365 Fax: 815.860.1760

T K Group, Inc
1781 South Bell School Rd
Cherry Valley, IL 61016
Office: 815.332.3460 Fax: 815.860.1760

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

COMPANY:		**LOCATION:**	
PATIENT:		**ADDRESS:**	
EMPLOYEE ID:	**DOB: AGE:**	**SEX: M F**	**EMAIL:**

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? <u>If you have never used a respirator or mask, check Unknown</u>.**
    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□

<u>PART A SECTION 2.1</u>

<u>FULL FACE/SCBA (MANDATORY)</u>

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 □ 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□

PHYSICIAN OR LICENSED HEALTHCARE PROFFESIONAL 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