

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Part A

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

To the employee, Patient ID: _____ 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 must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the healthcare professional who will review it.

Part A. Section 1. (Mandatory)

The following information must be provided by every employee who has been selected to use any type of respirator. (please print)

1. Today's Date: _____
2. Your Name: _____
3. Your age (to nearest year): _____
4. Sex: Male Female
5. Your height: _____ ft. _____ in.
6. Your weight: _____ lbs.
7. Your job title: _____ Job title not in list: _____
8. A phone number where you can be reached by the healthcare professional who reviews this questionnaire (include the Area Code): _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire? Yes No
11. 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 (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator? Yes No
If "yes" what type(s): _____

Part A. Section 2. (Mandatory)

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator.

Yes No

- | | | |
|--|--------------------------|--------------------------|
| 1. Do you <i>currently</i> smoke tobacco, or have you smoked tobacco in the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you <i>ever had</i> any of the following conditions? | | |
| a. Seizures (fits): | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Diabetes (sugar disease): | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Allergic reactions that interfere with your breathing: | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Claustrophobia (fear of closed-in places): | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Trouble smelling odors: | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you <i>ever had</i> any of the following pulmonary or lung problems? | | |
| a. Asbestosis: | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Asthma: | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Chronic bronchitis: | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Emphysema: | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Pneumonia: | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Tuberculosis: | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Silicosis: | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Pneumothorax (collapsed lung): | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Lung cancer: | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Broken ribs: | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Any chest injuries or surgeries: | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Any other lung problem that you've been told about: | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you <i>currently</i> have any of the following symptoms of pulmonary or lung illness? | | |
| a. Shortness of breath: | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Shortness of breath when walking with other people at an ordinary pace or level ground: | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have to stop for breath when walking at your own pace on level ground: | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Shortness of breath when washing or dressing yourself: | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Shortness of breath that interferes with your job: | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Coughing that produces phlegm (thick sputum): | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Coughing that wakes you early in the morning: | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Coughing that occurs mostly when you are lying down: | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Coughing up blood in the last month: | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Wheezing: | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Wheezing that interferes with your job: | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Chest pain when you breathe deeply: | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Any other symptoms that you think may be related to lung problems: | <input type="checkbox"/> | <input type="checkbox"/> |

Part A. Section 2. (Mandatory) (Continued)

	Yes	No
5. Have you <i>ever had</i> any of the following cardiovascular or heart problems?		
a. Heart attack:	<input type="checkbox"/>	<input type="checkbox"/>
b. Stroke:	<input type="checkbox"/>	<input type="checkbox"/>
c. Angina:	<input type="checkbox"/>	<input type="checkbox"/>
d. Heart failure:	<input type="checkbox"/>	<input type="checkbox"/>
e. Swelling in your legs or feet (not caused by walking):	<input type="checkbox"/>	<input type="checkbox"/>
f. Heart arrhythmia (heart beating irregularly):	<input type="checkbox"/>	<input type="checkbox"/>
g. High blood pressure:	<input type="checkbox"/>	<input type="checkbox"/>
h. Any other heart problem that you've been told about:	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you <i>ever had</i> any of the following cardiovascular or heart problems?		
a. Frequent pain or tightness in your chest:	<input type="checkbox"/>	<input type="checkbox"/>
b. Pain or tightness in your chest during physical activity:	<input type="checkbox"/>	<input type="checkbox"/>
c. Pain or tightness in your chest that interferes with your job:	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past two years, have you noticed your heart skipping or missing a beat:	<input type="checkbox"/>	<input type="checkbox"/>
e. Heartburn or indigestion that is not related to eating:	<input type="checkbox"/>	<input type="checkbox"/>
f. Any other symptoms that you think may be related to heart or circulation problems:	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you <i>currently</i> take medication for any of the following problems?		
a. Breathing or lung problems:	<input type="checkbox"/>	<input type="checkbox"/>
b. Heart trouble:	<input type="checkbox"/>	<input type="checkbox"/>
c. Blood pressure:	<input type="checkbox"/>	<input type="checkbox"/>
d. Seizures (fits):	<input type="checkbox"/>	<input type="checkbox"/>
8. If you've used a respirator, have you <i>ever had</i> any of the following problems?		
a. Eye irritation:	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin allergies or rashes:	<input type="checkbox"/>	<input type="checkbox"/>
c. Anxiety:	<input type="checkbox"/>	<input type="checkbox"/>
d. General weakness or fatigue:	<input type="checkbox"/>	<input type="checkbox"/>
e. Any other problem that interferes with your use of a respirator:	<input type="checkbox"/>	<input type="checkbox"/>
9. Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire?	<input type="checkbox"/>	<input type="checkbox"/>

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

	Yes	No
10. Have you <i>ever lost</i> vision in either eye (temporarily or permanently)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you <i>currently</i> have any of the following vision problems?		
a. Wear contact lenses:	<input type="checkbox"/>	<input type="checkbox"/>
b. Wear glasses:	<input type="checkbox"/>	<input type="checkbox"/>
c. Color blind:	<input type="checkbox"/>	<input type="checkbox"/>
d. Any other eye or vision problem:	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you <i>ever had</i> an injury to your ears, including a broken ear drum?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you <i>currently</i> have any of the following hearing problems?		
a. Difficulty hearing:	<input type="checkbox"/>	<input type="checkbox"/>
b. Wear a hearing aid:	<input type="checkbox"/>	<input type="checkbox"/>
c. Any other hearing or ear problem:	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you <i>ever had</i> a back injury?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you <i>currently</i> have any of the following musculoskeletal problems?		
a. Weakness in any of your arms, hands, legs, or feet:	<input type="checkbox"/>	<input type="checkbox"/>
b. Back pain:	<input type="checkbox"/>	<input type="checkbox"/>
c. Difficulty fully moving your arms and legs:	<input type="checkbox"/>	<input type="checkbox"/>
d. Pain or stiffness when you lean forward or backward at the waist:	<input type="checkbox"/>	<input type="checkbox"/>
e. Difficulty fully moving your head up or down:	<input type="checkbox"/>	<input type="checkbox"/>
f. Difficulty fully moving your head side to side:	<input type="checkbox"/>	<input type="checkbox"/>
g. Difficulty bending at your knees:	<input type="checkbox"/>	<input type="checkbox"/>
h. Difficulty squatting to the ground:	<input type="checkbox"/>	<input type="checkbox"/>
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs:	<input type="checkbox"/>	<input type="checkbox"/>
j. Any other muscle or skeletal problem that interferes with using a respirator:	<input type="checkbox"/>	<input type="checkbox"/>

Examiner Comments:

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Part B Discretionary Questions

Date: _____

Name: _____ Patient ID: _____ Age: _____ Sex: M F

Job Title: _____ Job not in list: _____

1. In your present job are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen? Yes No

If "Yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you are working under these conditions? Yes No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals? Yes No

If "yes", name the chemicals if you know them:

3. Have you ever worked with any of the materials, or under any of the conditions listed below:

- | | |
|--|--|
| a. Asbestos | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Silica (e.g., sandblasting) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Tungsten/cobalt (e.g., grinding or welding this material) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Beryllium | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Aluminum | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Coal (e.g., mining) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Iron | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Tin | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. Dusty environments | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. Any other hazardous exposures | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If "yes," describe these exposures:

4. List any second jobs or side businesses you have:

5. List your previous occupations:

6. List your current and previous hobbies:

7. Have you been in the military services? Yes No

If "yes" were you exposed to biological or chemical agents (either in training or combat)? Yes No

8. Have you ever worked on a HAZMAT team? Yes No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)? Yes No

If "Yes," name the medications if you know them:

10. Will you be using any of the following items with your respirator(s)?
- | | |
|--------------------------------|--|
| a. HEPA filters | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Canisters (e.g., gas masks) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Cartridges | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Part B. (Discretionary questions - continued)

11. How often are you expected to use the respirator(s)? (check all answers that apply to you)

- a. Escape only (no rescue duties)
- b. Emergency rescue only
- c. Less than 5 hrs. per week
- d. Less than 2 hrs. per day
- e. 2 to 4 hrs. per day
- f. over 4 hrs. per day

<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Yes	<input type="checkbox"/> No

12. During the period you are using your respirator(s), is your work effort:

- a. **Light** (less than 200 kcal per hour)

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If "yes", how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of a light work effort are *sitting* while writing, typing, drafting, or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines.

- b. **Moderate** (200 to 350 kcal per hour):

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If "yes", how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of moderate work effort are *sitting* while nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; *walking* on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

- c. **Heavy** (above 350 kcal per hour):

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If "yes", how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of heavy work are *lifting* a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; *shoveling*; *standing* while bricklaying or chipping castings; *walking* up an 8-degree grade about 2 mph; *climbing* stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you are using your respirator?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If "yes," describe this protective clothing and/or equipment:

14. Will you be working under hot conditions (temperature exceeding 77 deg. F)?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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15. Will you be working under humid conditions?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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16. Describe the work you will be doing while using your respirator(s):

17. Describe any special or hazardous conditions you might encounter when you are using your respirator(s) (for example, confined spaces, life-threatening gases):

18. Provide the following information, if you know it, for each toxic substance that you will be exposed to when using your respirator(s):

Name of the first toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the second toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the third toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of any other toxic substances that you will be exposed to while using your respirator(s):

19. Describe any special responsibilities you will have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):