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RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

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. Your employer must tell you how to send or deliver this questionnaire to the health care professional who will review it.

PART A. SECTION 1. MANDATORY

Every employee selected to use any type of respirator must provide the following information (please print).

Date: ____________________________________ Company__________________________

Name: ____________________________________ Address:___________________________

Job title: __________________________________

Age ___________ Sex: M F Height: ____________ Weight: _________________

Phone Number: ( ) ______________

Best phone number for health care professional to use: ( ) ______________

The best time to contact you ___________________________________

Has your employer told you how to contact the health care professional who will review this questionnaire? Yes No

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 type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Have you worn a respirator? Yes No

If “yes,” what type(s)? ____

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 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. Silicosis Yes No
   c. Asthma Yes No
   d. Pneumothorax (collapsed lung) Yes No
   e. Chronic bronchitis Yes No
   f. Lung cancer Yes No
   g. Emphysema Yes No
   h. Broken ribs Yes No
   i. Pneumonia Yes No
   j. Any chest injuries or surgeries Yes No
   k. Tuberculosis Yes No
   l. Any other lung problem that you have been told about Yes No

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   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 (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 that you think may be related to lung problems Yes No

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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 problems that you have 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 which interferes with job duties? Yes No
   d. In the past 2 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 have used a respirator, have you ever had any of the following problems? (If you have never used a respirator continue to question 9.
   a. Eye irritation Yes No
   b. Skin allergies or rashes Yes No
   c. Anxiety Yes No
   d. General weakness of fatigue Yes No
   e. Any other problem that interferes with your use of a respirator Yes No

9. Would you like to discuss your answers with the health care professional who will review this questionnaire? Yes No

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Questions 10 to 15 must be answered if you will use either a full-face respirator or a self-contained 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?
   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. Wear a hearing aid Yes No
   c. Any other hearing or ear problem 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 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 pounds Yes No
   j. Other muscle or skeletal problem which interfere with respirator use Yes No

Employee Signature Date