Infirmary Occupational Health
INFIRMARY HEALTH

Respirator Medical Evaluation Questionnaire

Company Name: ____

To the employee:
Can you read (circle one):___ 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 must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care 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 (check one): ___Male ___Female

5. Your height: ________ ft. ________ in.

6. Your weight: ________ lbs.

7. Your job title: ____

8. A phone number where you can be reached by the health care 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 (check one): ___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 (check one): ___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 (check one "yes" or "no").

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month: (check one): ___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. Asthma: ___Yes ___ No
   c. Chronic bronchitis: ___Yes ___ No
   d. Emphysema: ___Yes ___ No
   e. Pneumonia: ___Yes ___ No
   f. Tuberculosis: ___Yes ___ No
   g. ilicosis: ___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
   I. Any other lung problem that you've 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
   I. 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 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 problem that 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 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've used a respirator, have you **ever had** any of the following problems? (If you've never used a respirator, check the following space and go to question 9:)
    a. Eye irritation: ___Yes ___ No
    b. Skin allergies or rashes: ___Yes ___ No
    c. Anxiety: ___Yes ___ No
    d. General weakness or fatigue: ___Yes ___ No
    e. Any other problem that interferes with your use of a respirator: ___Yes ___ No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: ___Yes ___ No

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.

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 lbs: ___Yes ___ No
j. Any other muscle or skeletal problem that interferes with using a respirator: ___Yes ___ No

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

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're 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: ___Yes ___ No
b. Silica (e.g., in sandblasting): ___Yes ___ No
c. Tungsten/cobalt (e.g., grinding or welding this material): ___Yes ___ No
d. Beryllium: ___Yes ___ No
e. Aluminum: ___Yes ___ No
f. Coal (for example, mining): ___Yes ___ No
g. Iron: ___Yes ___ No
h. Tin: ___Yes ___ No
i. Dusty environments: ___Yes ___ No
j. Any other hazardous exposures: ___Yes ___ 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: ___Yes ___ No
   b. Canisters (for example, gas masks): ___Yes ___ No
   c. Cartridges: ___Yes ___ No

11. How often are you expected to use the respirator(s) (check "yes" or "no" for all answers that apply to you)?:
   a. Escape only (no rescue): ___Yes ___ No
   b. Emergency rescue only: ___Yes ___ No
   c. Less than 5 hours per week: ___Yes ___ No
   d. Less than 2 hours per day: ___Yes ___ No
   e. 2 to 4 hours per day: ___Yes ___ No
   f. Over 4 hours per day: ___Yes ___ No

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

   a. **Light** (less than 200 kcal per hour): ___Yes ___ No

If "yes," how long does this period last during the average shift: ___________ hours ___________ minutes.

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): ___Yes ___ No

If "yes," how long does this period last during the average shift: ___________ hours ___________ minutes.

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.

3. **Heavy** (above 350 kcal per hour): ___Yes ___ No
If "yes," how long does this period last during the average shift: ____________ hours ____________ minutes.

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're using your respirator: ___Yes ___ No

If "yes," describe this protective clothing and/or equipment: ____

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): ___Yes ___ No

15. Will you be working under humid conditions: ___Yes ___ No

16. Describe the work you'll be doing while you're using your respirator(s):
____

17. Describe any special or hazardous conditions you might encounter when you're 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'll be exposed to when you're 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: ____

The name of any other toxic substances that you'll be exposed to while using your respirator:
____
____
____

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