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# Respirator Medical Evaluation Questionnaire

**Instructions: Your employer must allow you to complete this questionnaire during normal work hours, or at a time and place which 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. All questions should be referred to HealthWorks WNY - not your employer.**

**Did you read and complete this form yourself or did someone help you complete it?** SELF ☐ With HELP ☐

## Part A - Section 1 MANDATORY

**Please PRINT LEGIBLY and provide COMPLETE information to the following questions:**

| | |
|---|---|
| Name | Today's Date |
| Date of Birth / Age | Sex Male ☐ Female ☐ |
| Height | Weight |
| Has your employer told you how to contact the health care professional who will review this questionnaire? Yes ☐ No ☐ | Name of Employer |
| Phone number where you can be reached | Best time to call you at this number |

Check the type of respirator you will use. (You can check more than one)

☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only)
☐ Other type (for example, half or full-face piece type, powered air purifying, supplied air, SCBA)

| | |
|---|---|
| Have you worn a respirator (circle 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. (Please check box if answer is YES - otherwise leave box unchecked)**

1. Do your currently smoke tobacco or have you smoked tobacco in the last month? YES ☐

2. Have you *ever had* any of the following conditions?
   - a. Seizures (fits) ☐
   - b. Diabetes (high Blood Sugar) ☐
   - c. Allergic reactions that interfere with your breathing ☐
   - d. Claustrophobia (fear of closed-in-places) ☐
   - e. Trouble smelling odors ☐

3. Have you *ever had* any of the following pulmonary or lung problems?
   - a. Asbestosis ☐
   - b. Asthma ☐
   - c. Chronic Bronchitis ☐
   - d. Emphysema ☐
   - e. Pneumonia ☐
   - f. Tuberculosis ☐
   - g. Silicosis ☐
   - h. Pneumothorax (collapsed lung) ☐
   - i. Lung Cancer ☐
   - j. Broken ribs ☐
   - k. Any chest injuries or chest surgeries ☐
   - l. Any other lung problem that you've been told about ☐

4. Do you *currently* have any of the following symptoms of pulmonary or lung disease? YES
   - a. Shortness of breath ☐
   - b. Shortness of breath when walking fast on level ground or walking up slight hill or incline ☐
   - c. Shortness of breath when walking with other people at an ordinary pace on level ground ☐
   - d. Have to stop for breath when walking with other people at an ordinary pace on level ground ☐
   - e. Shortness of breath when washing or dressing yourself ☐
   - f. Shortness of breath that interferes with your job ☐
   - g. Coughing that produces phlegm (thick sputum) ☐
   - h. Coughing that wakes you early in the morning ☐
   - I. Coughing that occurs mostly when you are lying down ☐
   - j. Coughing up blood in the last month ☐
   - k. Wheezing ☐
   - l. Wheezing that interferes with your job ☐
   - m. Chest pain when you breathe deeply ☐
   - n. Any other symptoms that you think may be related to lung problems ☐

**Part A - Section 2 MANDATORY (continued)**

5. Have you *ever had* any of the following cardiovascular or heart problems? YES
   a. Heart attack - - - - - - - - - - - - - - - - - - - - - - - - - ☐
   b. Stroke - - - - - - - - - - - - - - - - - - - - - - - - - - - - - ☐
   c. Angina - - - - - - - - - - - - - - - - - - - - - - - - - - - - - ☐
   d. Heart failure - - - - - - - - - - - - - - - - - - - - - - - - - ☐
   e. Swelling in your legs or feet (not caused by walking) - - - - - - - - - - - - - - - - - - - - - - - - - ☐
   f. Heart arrhythmia (heart beating irregularly)- - - - - ☐
   g. High Blood pressure - - - - - - - - - - - - - - - - - - - - ☐
   h. Any other heart problem that you've been told about - - - - - - - - - - - - - - - - - - - - - - - - - ☐

6. Have you *ever had* any of the following cardiovascular or heart symptoms?
   a. Frequent pain or tightness in your chest- - - - - - ☐
   b. Pain or tightness in your chest during physical activity - - - - - - - - - - - - - - - - - - - - - - - ☐
   c. Pain or tightness in your chest that interferes with your job - - - - - - - - - - - - - - - - - - - ☐
   d. In the past two years, have you noticed - - - - - - - your heart skipping or missing a beat - - - - - - - - ☐
   e. Heartburn or indigestion that is not related to eating - - - - - - - - - - - - - - - - - - - - - - ☐
   f. Any other symptoms that you think may be related to heart or circulation problems - - - - - ☐

7. Do you *currently* take medication for any of the following problems?
   a. Breathing or lung problems - - - - - - - - - - - - - - ☐
   b. Heart trouble - - - - - - - - - - - - - - - - - - - - - - - - ☐
   c. Blood pressure - - - - - - - - - - - - - - - - - - - - - - - ☐
   d. Seizures (fits) - - - - - - - - - - - - - - - - - - - - - - - ☐

8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, go to question 9
   a. Eye irritation - - - - - - - - - - - - - - - - - - - - - - - - ☐
   b. Skin allergies or rashes - - - - - - - - - - - - - - - - - ☐
   c. Anxiety- - - - - - - - - - - - - - - - - - - - - - - - - - - - ☐
   d. General weakness or fatigue - - - - - - - - - - - - - ☐
   e. Any other problem that interferes with your use of a respirator - - - - - - - - - - - - - - - - - ☐

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? - - - - - - - - - - - - - - - - - - - - - - - - ☐

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 ☐

11. Do you currently have any of the following vision problems?
   a. Wear contact lenses - - - - - - - - - - - - - - - - - - - ☐
   b. Wear glasses - - - - - - - - - - - - - - - - - - - - - - - - ☐
   c. Color blind - - - - - - - - - - - - - - - - - - - - - - - - - ☐
   d. Any other eye or vision problem - - - - - - - - - - - ☐

12. Have you *ever* had an injury to your ears, including a broken ear drum?- - - - - - - - - - - - - - - ☐

13. Do you *currently have* any of the following hearing problems?
   a. Difficulty hearing - - - - - - - - - - - - - - - - - - - - - ☐
   b. Wear a hearing aid - - - - - - - - - - - - - - - - - - - - ☐
   c. Any other hearing or ear problem - - - - - - - - - - ☐

14. Have you ever had a back injury? - - - - - - - - - - - - - ☐

15. Do you *currently* have any of the following muscular-skeletal problems?
   a. Weakness in any of your arms, hands, legs, or feet- - - - - - - - - - - - - - - - - - - - - - - - - ☐
   b. Back pain- - - - - - - - - - - - - - - - - - - - - - - - - - - ☐
   c. Difficulty fully moving your arms and legs- - - - - ☐
   d. Pain or stiffness when you lean forward or backward at the waist - - - - - - - - - - - - - - - - - ☐
   e. Difficulty fully moving your head up or down- - - - - - - - - - - - - - - - - - - - - - - - - - - - - ☐
   f. Difficulty fully moving your head side to side- - - - - - - - - - - - - - - - - - - - - - - - - - - - - ☐
   g. Difficulty bending at your knees- - - - - - - - - - - ☐
   h. Difficulty squatting to the ground - - - - - - - - - - ☐
   i. Climbing a flight of stairs or ladder carrying more than 25 lbs.- - - - - - - - - - - - - - - - - ☐
   j. Any other muscle or skeletal problem that interferes with using a respirator - - - - - - - - ☐

Please comment on any **YES** answers:

**Notice:**

**I certify that the above information is true and accurate to the best of my knowledge. I understand that the licensed healthcare professional's medical opinion regarding any ability to wear a respirator is based upon the information provided. I understand that knowingly submitting false information could result in an incorrect medical opinion. If I become aware of additional or inaccurate information, I will immediately notify the licensed healthcare professional so they are able to reassess my ability to wear a respirator.**

| Employee's Name (Print) | Employee's Signature |
|---|---|
| Healthcare provider reviewing questionnaire (Print) | Healthcare provider's Signature |

Date Questionnaire Reviewed