APPENDIX F

Respirator Medical Evaluation Questionnaire

Part A. Section 1. (Mandatory) Every employee who has been selected to use any type of respirator (please print) must provide the following information.

Today's date _____ Date of Birth: _____

Name _____ SSN: _____

Job Title _____ Sex: Male ◯ Female ◯

Home Phone: _____ Height: ____ (ft) ____ (in) Weight ____ (lbs)

Work Phone: _____

Can you read English? ..... Yes ◯ NO ◯

Has your employer told you how to contact the health care professional who will review this? 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

☐ Half-face

☐ Full-facepiece type (includes gas mask)

☐ Powered-air purifier

☐ Supplied-air

☐ Self-contained breathing apparatus

Have you worn a respirator in the past?: ..... Yes ◯ NO ◯

If "yes," what type(s): _____

Physical exertion while wearing a respirator ☐ Mild ☐ Moderate ☐ Strenuous

Maximum time you wear a respirator in a single day?: ____ hours

Do you exercise? ..... Yes ◯ NO ◯

If "yes," describe how often and what exercise activities are: _____

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 select "yes" or "no").

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes ◯ NO ◯

If Yes, how many packs per day? ☐ 1/2 or less ☐ 1 ☐ 2 ☐ 2 or more

How many years have you smoked? ☐ 1-9 ☐ 10-19 ☐ 20-29 ☐ 30 or more

2. Have you ever had any of the following conditions?

Seizures (fits) Yes ◯ NO ◯

Diabetes (sugar disease) Yes ◯ NO ◯

Allergic reactions that interfere with your breathing Yes ◯ NO ◯

Claustrophobia (fear of closed-in places) Yes ◯ NO ◯

Trouble smelling odors Yes ◯ NO ◯

3. Have you ever had any of the following pulmonary or lung problems?

Asbestosis Yes ◯ NO ◯

Asthma Yes ◯ NO ◯

Chronic bronchitis Yes ◯ NO ◯

Emphysema: Yes ◯ NO ◯

Pneumonia Yes ◯ NO ◯

Tuberculosis Yes ◯ NO ◯

Silicosis Yes ◯ NO ◯

Pneumothorax (collapsed lung) Yes ◯ NO ◯

Lung cancer Yes ◯ NO ◯

Broken ribs. Yes ◯ NO ◯

Any chest injuries or surgeries. Yes ◯ NO ◯

Any other lung problem that you've been told about: Yes ◯ NO ◯

Name _____

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

Shortness of breath.	Yes ◯ NO ◯
Shortness of breath when walking fast on level ground or walking up a slight hill/incline	Yes ◯ NO ◯
Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes ◯ NO ◯
Have to stop for breath when walking at your own pace on level ground:	Yes ◯ NO ◯
Shortness of breath when washing or dressing yourself:	Yes ◯ NO ◯
Shortness of breath that interferes with your job.	Yes ◯ NO ◯
Coughing that produces phlegm (thick sputum)	Yes ◯ NO ◯
Coughing that wakes you early in the morning.	Yes ◯ NO ◯
Coughing that occurs mostly when you are lying down	Yes ◯ NO ◯
Coughing up blood in the last month	Yes ◯ NO ◯
Wheezing.	Yes ◯ NO ◯
Wheezing that interferes with your job:	Yes ◯ NO ◯
Chest pain when you breathe deeply.	Yes ◯ NO ◯
Any other symptoms that you think may be related to lung	Yes ◯ NO ◯

5. Have you ever had any of the following cardiovascular or heart problems?

Heart attack	Yes ◯ NO ◯
Stroke.	Yes ◯ NO ◯
Angina:	Yes ◯ NO ◯
Heart Failure	Yes ◯ NO ◯
Swelling in your legs or feet (not caused by walking):	Yes ◯ NO ◯
Heart arrhythmia (heart beating irregularly):	Yes ◯ NO ◯
High blood pressure	Yes ◯ NO ◯
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?

Frequent pain or tightness in your chest :	Yes ◯ NO ◯
Pain or tightness in your chest during physical activity	Yes ◯ NO ◯
Pain or tightness in your chest that interferes with your job	Yes ◯ NO ◯
In the past two years, have you noticed your heart skipping or missing a beat :	Yes ◯ NO ◯
Heartburn or symptoms that is not related to eating	Yes ◯ NO ◯
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?

Breathing or lung problems:	Yes ◯ NO ◯
Heart trouble.	Yes ◯ NO ◯
Blood Pressure:	Yes ◯ NO ◯
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)

Eye irritation.	Yes ◯ NO ◯
Skin allergies or rashes.	Yes ◯ NO ◯
Anxiety:	Yes ◯ NO ◯
General weakness or fatigue	Yes ◯ NO ◯
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 ◯

Name _____

SUPPLEMENTAL: If you are required to use a full-face peice respirator or a Self-Contained Breathing Aparatus (SCBA), complete the following: (If you do not, please sign below.)

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?

- Wear glasses. Yes ◯ NO ◯
- Wear contact lenses. Yes ◯ NO ◯
- Color blind Yes ◯ NO ◯
- 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?

- Difficulty hearing Yes ◯ NO ◯
- Wear a hearing aid: Yes ◯ NO ◯
- 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?

- Weakness in any of your arms, hands, legs, or feet: Yes ◯ NO ◯
- Back pain Yes ◯ NO ◯
- Difficulty fully moving your arms and legs. Yes ◯ NO ◯
- Pain or stiffness when you lean forward or backward at the waist: Yes ◯ NO ◯
- Difficulty fully moving your head up or down Yes ◯ NO ◯
- Difficulty fully moving your head side to side Yes ◯ NO ◯
- Difficulty bending at your knees Yes ◯ NO ◯
- Difficulty squatting to the ground: Yes ◯ NO ◯
- Climbing a flight of stairs or a ladder carrying more than 25 lbs. Yes ◯ NO ◯
- Any other muscle or skeletal problem that interferes with using a respirator Yes ◯ NO ◯

Any additional comments you would like to make:

_____

To the best of my knowledge, the information I have provided is true and accurate

Employee Signature _____ **Date** _____

TO BE COMPLETED BY THE EXAMINER/REVIEWER:

This employee has been found to be physically able to use the following (check each [ ] that applies):

- ☐ Single use, filter mask (four attachment points)
- ☐ Half-faced cartridge-type, negative pressure
- ☐ Full-faced cartridge-type respirator, negative pressure
- ☐ Half-faced powered cartridge-type (PAPR)
- ☐ Full-faced powered cartridge-type (PAPR)
- ☐ Self-contained breathing apparatus (SCBA)
- ☐ Hood/helmet powered cartridge-type (PAPR)
- ☐ Half-faced/Full-faced/Hood/Helmet (NOT positive pressure)

Restrictions / Limitations (if any) when wearing a respirator:

_____

- ☐ ***This employee has been found to be physically NOT able to use a respirator***
- ☐ ***There is insufficient information to make a determination at this time***
- ☐ ***The mandatory questionnaire has been reviewed, and the employee has been found to be physically able to use a respirator.***
- ☐ ***The mandatory questionnaire has been reviewed but there is insufficient information to make a determination at this time.***

This respirator clearance expires 1 ◯ 2 ◯ 3 ◯ years from the date below. (*If not marked, clearance expires in 1 year*)

Reviewer's Name (Print) _____ **Reviewer's Signature** _____ **Date:** _____