RESPIRATORY MEDICAL EVALUATION QUESTIONNAIRE

(Adapted from the Federal Register/OSHA Respiratory Protection, Final Rule 4/98)

PART A: SECTION 1

Name (first, middle, last):	**Age**:	**SSN**:	**Today's Date**:
Sex (circle): M / F	**Company Name**:	**Location**:	**Job Title**:	**Telephone**: ( )_____ ( ) _____
Height: ___ ft. __ in.	**Weight**: _____ lbs.	**For Staff Use: BP**: _____ **Pulse**: _____		

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. This questionnaire will be administered and reviewed by the health care professionals at LBMC/ASAP/OSCA.

Please answer the following questions :	**Yes**	**No**
1) Do you know how to contact the health care professional who will review this questionnaire? *This will be the group doing the testing*		
2) Indicate the type of respirator you will use (you can select more than one category*): N, R, or P disposable respirator (filter-mask, non cartridge type only:* (Specify):_____		
Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus*)*: (Specify.) _____		
Have you ever worn a respirator? If yes, what type(s): _____		

PART A: SECTION 2

	Yes	**No**
1) Do you currently smoke tobacco, or have you smoked tobacco in the last month? *If yes What do you smoke (pipe, cigars, cigarettes)? _____ How much do you smoke a day? _____ How many years have you smoked?_____*		
2) Have you ever had the following conditions: *If yes, indicate: When you were diagnosed [age or # of years ago]? b) If you are under a doctor's care? c) When you last saw the doctor? d) Medications and if so what [name, strength and times/day]?*		
a) Seizures (fits)?		
b) Diabetes (sugar disease)?		
c) Allergic reactions that interfere with your breathing?		
d) Claustrophobia (fear of closed-in places)? If YES - *Does it interfere with your job **YES / NO** _____ or wearing a respirator? **YES / NO** _____*		
e) Trouble smelling odors?		
3) PULMONARY OR LUNG PROBLEMS: Have you ever had the following pulmonary or lung problem: *If "YES", indicate: When you were diagnosed [age or # of years ago]? b) If you are under a doctor's care? c) When you last saw the doctor? d) Medications and if so what [name, strength and times/day]? Do you have any breathing problems today?*	**Yes**	**No**
a) Asbestosis?		
b) Asthma? *If YES: Do you carry an inhaler? **YES / NO** _____ Name of medication? _____How often do you use it? _____(Times a day /times a week / times a month) **[You must carry it on you while at work/ wearing a respirator]*		
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 surgeries?		
l) Any other lung problem that you've been told about? *If "YES", Specify what problem, whether you have seen a doctor for this, and what medicines you are taking:* _____		

4) **Do you currently have any of the following symptoms of pulmonary or lung illness: "***Currently" does not mean after strenuous activity or exercise.*	**Yes**	**No**
a) Shortness of breath?		
b) Shortness of breath when walking fast on level ground or walking up a 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 at your own 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? *If "YES", Specify what problem, whether you have seen a doctor for this, and what medicines you are taking:* _____		
o) *Do you currently have a cold?* *If YES, How often do you get a cold _____(Times / year).Have you seen a doctor* ***YES / NO*** _____ *If you are on medication, name of medication?* _____		

5) **CARDIOVASCULAR OR HEART PROBLEMS: Have you ever had any of the following cardiovascular or heart problem** *If "YES", indicate: When you were diagnosed [age or # of years ago]? b) If you are under a doctor's care? c) When you last saw the doctor? d) Medications and if so what [name, strength and times/day]? Do you have any problems today?*	**Yes**	**No**
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? *If "YES", Specify what problem, whether you have seen a doctor for this, and what medicines you are taking:* _____		

6) **Have you ever had any of the following cardiovascular or heart symptoms:** *If "YES" How often (times/week), how severe[Scale 1/10], have you seen a doctor for symptom/s? Are you taking medications? if "YES" what medicines [name, strength and times/day]and do you have any symptoms today?*	**Yes**	**No**
a) Frequent pain or tightness in your chest?		
b) Frequent 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?		
Any other symptoms that you think may be related to heart or circulation problems? *If "YES", Specify what problem, whether you have seen a doctor for this, and what medicines you are taking:* _____		

7) **CURRENT MEDICATIONS: Do you currently take medications for any of the following problems:** *Medications and if so what [name, strength and times/day]?*	**Yes**	**No**
a) Breathing or lung problems?		
b) Heart trouble?		
c) Blood pressure?		
d) Seizures?		
e) Any other medications for any reason (including over-the-counter medications)? *If "YES", Specify medications [name, strength and times/day]? And why you are taking them?* _____		

	Yes	No
8) PROBLEMS WHILE USING A RESPIRATOR: *If "YES", did it interfere with your wearing a respirator? Have you tried wearing a respirator made of a different material and if so did that help?*		
Have you ever had any of the following problems while using a respirator? If you've never used one, check this ❒ box and proceed to Question 9.		
a) Eye irritation?		
b) Skin allergies or rashes?		
c) Anxiety?		
d) General weakness or fatigue?		
e) Any other problems that interferes with your use of a respirator? *Specify (What) problem?* _____		
9) Would you like to discuss specific issues with the health care professional who will review this questionnaire? *If "YES", Specify issue/s?* _____		
Questions 10 to 15 below must be answered by every employee who has to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have to use other types of respirators, answering these questions is voluntary.		
VISION PROBLEMS:	**Yes**	**No**
10) Have you ever lost vision in either eye (temporarily or permanently)? *If "YES", one eye or both_____ When? _____ How did it happen? _____ Did your vision return? **YES / NO** _____ What treatment did you receive?_____*		
11) Do you currently have any of the following vision problems:		
a) Wear contact lenses?		
b) Wear glasses? *If you cannot work safely without glasses, speak to your safety manager about obtaining specialized inserts. Do not wear your glasses with a full face respirator because your glasses will compromise the seal of the mask.*		
c) Color blindness?		
d) Any other eye or vision problems? *Specify (What) problem?* _____		
HEARING PROBLEMS:	**Yes**	**No**
12) Have you ever had an injury to your ears, including a broken eardrum? *If "YES", one ear or both_____ When? _____ How did it happen? _____ Did you recover? **YES / NO** _____ What treatment did you receive?_____*		
13) Do you currently have any of the following hearing problems:		
a) Do you currently have difficulty hearing?		
b) Do you currently wear a hearing aid?		
c) Do you currently have any other hearing or ear problem? *If "YES", Specify what problem, whether you have seen a doctor for this, and what medicines you are taking:* _____		
MUSCULOSKELETAL PROBLEMS: *If "YES", indicate: When you were diagnosed [age or # of years ago]? b) If you are under a doctor's care? c) When you last saw the doctor? d) Medications and if so what [name, strength and times/day] ? Do you have any problems today?*	**Yes**	**No**
14) Have you ever had a back injury?		
15) Do you currently have any of the following musculoskeletal 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) Difficulty 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? *If "YES", Specify what problem, whether you have seen a doctor for this, and what medicines you are taking:* _____		
Additional Notes: _____		