Respirator Medical Evaluation Questionnaire

This questionnaire will be reviewed by a licensed health care professional.

PLEASE PRINT: Date: _____

Name: (First)_____ (Last)_____

Date of Birth _____/_____/____ Wt: _____ lbs.

Job Title: _____ Unit: _____

If you are not sure of an answer below, you may leave it blank.

Have you worn a respirator (check on): Yes____No____ If Yes, what type: _____

Please check Yes or No

Yes	No

1. Did you currently smoke tobacco in the last month?

2. Have you had any of the following conditions?

a. Seizures (fits):		
b. Diabetes (sugar disease):		
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?

	Yes	No
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 surgeries		
l. Any other lung problems that you've been told about		

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

	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 a 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 jobs:		
	Yes	No
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		

5. Have you ever had any of the following cardiovascular to heart problems:

	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 problems that you've been told about		

6. Have you ever had any of the following cardiovascular or heart symptoms:

	Yes	No
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:

	Yes	No
a. Breathing or lung problems		
b. Heart trouble		
c. Blood pressure		
d. Seizures (fits)		

8. If you have never used a respirator, check the following space: _____, and go to Question 10.

9. If you have used a respirator, have you ever had any of the following problems:

	Yes	No
a. Eye irritation		
b. Skin allergies or rashes		
c. Anxiety		
d. General weakness or fatigue		
e. Any other problems that interfere with your use of a respirator		

Occupational Safety and Health Administration (OSHA) requires fit testing to be conducted at least annually. Fit testing must also be conducted whenever you have a change in your physical condition that could affect the fit of the respirator. Such changes could include (but not limited to):

- Large weight gain or loss
- Major dental work (such as new dentures)
- Facial surgery that may have changed the shape of your face, or significant scarring in the area of the seal

10. Would you like to talk to a health care professional, who will review the questionnaire, about your answers?

Yes	No

Employee Name (Print): _____

Employee Signature: _____ Date: _____

Staff is: ____cleared for Fit Testing ____ not cleared for Fit Testing

If not cleared for Fit Testing, state the reason:

_____

_____

Reviewed by:

Staff Name (Print): _____ RN/NP/PA/MD/DO

Staff Signature: _____ Date: _____