

Patient Name	
MHN	
Gender	
DOB	
Age	
Employer	

**Respiratory Medical Evaluation**

**Questionnaire**

**Statement of Understanding (Read carefully before signing)**

This examination is being performed at the request of your employer or prospective employer to determine your ability to wear a respirator. Medical information obtained during this examination may be shared with the party requesting the examination with your release.

Please be aware that if you have an existing medical record at Marshfield Clinic, that record may be reviewed by the person doing the examination to confirm or clarify background health information.

It is important that the answers to the following questions are accurate and complete. An examination for respirator wear does not take the place of a complete physical. We will not treat you or prescribe treatment for you, however you will be notified if we find something abnormal. Please see your own doctor for your health care needs. At your request, we can release the results of your examination to your doctor.

Release of the results of your examination is controlled by law, including the Americans with Disabilities Act (ADA). If you have questions, direct them to the person doing the examination.

Name				Today's date (month/day/year)	
Date of birth (month/day/year)	Age (to nearest year)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height ft. in.	Weight lbs.	
Job title					

Anticipated location of exam &/or fit test if needed: Beaver Dam Chippewa Falls Dickinson  
Eau Claire Marshfield Neillsville Rice Lake Wausau

A phone number where you can be reached by the professionally licensed health care provider (PLHCP) who reviews this questionnaire (include the area code) ( \_\_\_\_\_ ) \_\_\_\_\_

The best time to call you at this number \_\_\_\_\_

Has your employer told you how to contact the PLHCP who will review this questionnaire:  Yes  No

Check (✓) the type of respirator you will use (you can check more than one category):

- N, R or P disposable respirator (filter-mask, non-cartridge type only)
- Other type (e.g. half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

Have you worn a respirator:  Yes  No If yes, what type(s) \_\_\_\_\_

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**Respiratory Medical Evaluation  
Questionnaire (Continued)**

**PART A: ALL RESPIRATORS**

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (check "Yes" or "No".)

	Yes	No
1. Do you <i>currently</i> smoke tobacco or have you smoked tobacco in the last month . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you <i>ever had</i> any of the following conditions:		
Seizures (fits) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (sugar disease) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Allergic reactions that interfere with your breathing . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobia (fear of closed-in places) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Trouble smelling odors . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you <i>ever had</i> any of the following pulmonary or lung problems:		
Asbestosis . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Asthma . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Silicosis . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Pneumothorax (collapsed lung) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Lung cancer . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Broken ribs . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Any chest injuries or surgeries . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Any other lung problem that you've been told about . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you <i>currently</i> have any of the following symptoms of pulmonary or lung illness:		
Shortness of breath . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath when walking fast on level ground or walking up a slight hill or incline . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath when walking with other people at an ordinary pace on level ground . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Have to stop for breath when walking at your own pace on level ground . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath when washing or dressing yourself . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath that interferes with your job . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Coughing that produces phlegm (thick sputum) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Coughing that wakes you early in the morning . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Coughing that occurs mostly when you are lying down . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood in the last month . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing that interferes with your job . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain when you breathe deeply . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Any other symptoms that you think may be related to lung problems . . . . .	<input type="checkbox"/>	<input type="checkbox"/>

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**Respiratory Medical Evaluation  
Questionnaire (Continued)**

	Yes	No
5. Have you <i>ever had</i> any of the following cardiovascular or heart problems:		
Heart attack .....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>
Angina .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart failure .....	<input type="checkbox"/>	<input type="checkbox"/>
Swelling in your legs or feet (not caused by walking) .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart arrhythmia (heart beating irregularly) .....	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>
Any other heart problem that you've been told about .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you <i>ever had</i> any of the following cardiovascular or heart symptoms:		
Frequent pain or tightness in your chest .....	<input type="checkbox"/>	<input type="checkbox"/>
Pain or tightness in your chest during physical activity .....	<input type="checkbox"/>	<input type="checkbox"/>
Pain or tightness in your chest that interferes with your job .....	<input type="checkbox"/>	<input type="checkbox"/>
In the past 2 years, have you noticed your heart skipping or missing a beat .....	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn or indigestion that is not related to eating .....	<input type="checkbox"/>	<input type="checkbox"/>
Any other symptoms that you think may be related to heart or circulation problems .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you <i>currently</i> take medication for any of the following problems:		
Breathing or lung problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble .....	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>
Seizures (fits) .....	<input type="checkbox"/>	<input type="checkbox"/>
8. If you've used a respirator, have you <i>ever had</i> any of the following problems (If you've never used a respirator, check (✓) here <input type="checkbox"/> and go to question 9):		
Eye irritation .....	<input type="checkbox"/>	<input type="checkbox"/>
Skin allergies or rashes .....	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety .....	<input type="checkbox"/>	<input type="checkbox"/>
General weakness or fatigue .....	<input type="checkbox"/>	<input type="checkbox"/>
Any other problem that interferes with your use of a respirator .....	<input type="checkbox"/>	<input type="checkbox"/>
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire .....	<input type="checkbox"/>	<input type="checkbox"/>

**I declare that my answers and statements are correct, complete, correctly recorded, and true to the best of my knowledge; and I understand that if employed, any false or misleading statements may result in termination at the employer's discretion.**

Signature \_\_\_\_\_

Date (month/day/year) \_\_\_\_\_

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**Respiratory Medical Evaluation  
Questionnaire (Continued)**

**PART B: FULL-FACE PIECE RESPIRATOR, SELF-CONTAINED BREATHING APPARATUS AND HAZMAT RESPIRATORS ONLY**

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. For employees who have been selected to use other types of respirators, answering these questions is voluntary.

	Yes	No
10. Have you ever <i>lost</i> vision in either eye (temporarily or permanently) .....	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you <i>currently</i> have any of the following vision problems:		
Wear contact lenses .....	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses .....	<input type="checkbox"/>	<input type="checkbox"/>
Color blind .....	<input type="checkbox"/>	<input type="checkbox"/>
Any other eye or vision problem .....	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever <i>had</i> an injury to your ears, including a broken ear drum .....	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you <i>currently</i> have any of the following hearing problems:		
Difficulty hearing .....	<input type="checkbox"/>	<input type="checkbox"/>
Wear a hearing aid .....	<input type="checkbox"/>	<input type="checkbox"/>
Any other hearing or ear problem .....	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever <i>had</i> a back injury .....	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you <i>currently</i> have any of the following musculoskeletal problems:		
Weakness in any of your arms, hands, legs, or feet .....	<input type="checkbox"/>	<input type="checkbox"/>
Back pain .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty fully moving your arms and legs .....	<input type="checkbox"/>	<input type="checkbox"/>
Pain or stiffness when you lean forward or backward at the waist .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty fully moving your head up or down .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty fully moving your head side to side .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty bending at your knees .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty squatting to the ground .....	<input type="checkbox"/>	<input type="checkbox"/>
Climbing a flight of stairs or a ladder carrying more than 25 lbs. ....	<input type="checkbox"/>	<input type="checkbox"/>
Any other muscle or skeletal problem that interferes with using a respirator .....	<input type="checkbox"/>	<input type="checkbox"/>

**PART C: FOR HAZMAT TEAM ONLY**

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.

	Yes	No
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 .....	<input type="checkbox"/>	<input type="checkbox"/>
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 .....	<input type="checkbox"/>	<input type="checkbox"/>
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 .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, name the chemicals if you know them _____		

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Questionnaire (Continued)**

	Yes	No
3. Have you ever worked with any of the materials, or under any of the conditions listed below:		
Asbestos .....	<input type="checkbox"/>	<input type="checkbox"/>
Silica (e.g. in sandblasting) .....	<input type="checkbox"/>	<input type="checkbox"/>
Tungsten/Cobalt (e.g. grinding or welding this material) .....	<input type="checkbox"/>	<input type="checkbox"/>
Beryllium .....	<input type="checkbox"/>	<input type="checkbox"/>
Aluminum .....	<input type="checkbox"/>	<input type="checkbox"/>
Coal (e.g. mining) .....	<input type="checkbox"/>	<input type="checkbox"/>
Iron .....	<input type="checkbox"/>	<input type="checkbox"/>
Tin .....	<input type="checkbox"/>	<input type="checkbox"/>
Dusty environments .....	<input type="checkbox"/>	<input type="checkbox"/>
Any other hazardous exposures .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, describe those 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 .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, were you exposed to biological or chemical agents (either in training or combat) .....	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever worked on a hazardous materials team .....	<input type="checkbox"/>	<input type="checkbox"/>
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) .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, name the medications if you know them _____		
10. Will you be using any of the following items with your respirator(s):		
HEPA (high efficiency particulate arrestor) filters .....	<input type="checkbox"/>	<input type="checkbox"/>
Canisters (e.g. gas masks) .....	<input type="checkbox"/>	<input type="checkbox"/>
Cartridges .....	<input type="checkbox"/>	<input type="checkbox"/>
11. How are you expected to use the respirator(s):		
Escape only (no rescue) .....	<input type="checkbox"/>	<input type="checkbox"/>
Emergency rescue only .....	<input type="checkbox"/>	<input type="checkbox"/>
Less than 5 hours per week .....	<input type="checkbox"/>	<input type="checkbox"/>
Less than 2 hours per day .....	<input type="checkbox"/>	<input type="checkbox"/>
2 to 4 hours per day .....	<input type="checkbox"/>	<input type="checkbox"/>

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Signature \_\_\_\_\_

Date (month/day/year) \_\_\_\_\_