Patient name			
MHN	DOB	Age	Gender

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) / /
MHN	Age (to nearest year)	Sex: ☐ Male ☐ Female	Height ft. in.	Weight lbs.	Date of birth (month/day/year) / /
Employer			Job title		

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) ____________________

This questionnaire is derived from the OSHA Respiratory Protection Standards 1910.134

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Patient name	MHN	DOB	Age	Gender

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 *currently* smoke tobacco or have you smoked tobacco in the last month	☐	☐
2. Have you *ever had* any of the following conditions:		
Seizures (fits)	☐	☐
Diabetes (sugar disease)	☐	☐
Allergic reactions that interfere with your breathing	☐	☐
Claustrophobia (fear of closed-in places)	☐	☐
Trouble smelling odors	☐	☐
3. Have you *ever had* any of the following pulmonary or lung problems:		
Asbestosis	☐	☐
Asthma	☐	☐
Chronic bronchitis	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐
Silicosis	☐	☐
Pneumothorax (collapsed lung)	☐	☐
Lung cancer	☐	☐
Broken ribs	☐	☐
Any chest injuries or surgeries	☐	☐
Any other lung problem that you've been told about	☐	☐
4. Do you *currently* have any of the following symptoms of pulmonary or lung illness:		
Shortness of breath	☐	☐
Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐	☐
Shortness of breath when walking with other people at an ordinary pace on level ground	☐	☐
Have to stop for breath when walking at your own pace on level ground	☐	☐
Shortness of breath when washing or dressing yourself	☐	☐
Shortness of breath that interferes with your job	☐	☐
Coughing that produces phlegm (thick sputum)	☐	☐
Coughing that wakes you early in the morning	☐	☐
Coughing that occurs mostly when you are lying down	☐	☐
Coughing up blood in the last month	☐	☐
Wheezing	☐	☐
Wheezing that interferes with your job	☐	☐
Chest pain when you breathe deeply	☐	☐
Any other symptoms that you think may be related to lung problems	☐	☐

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Respiratory Medical Evaluation
Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

	Yes	No
5. Have you *ever had* any of the following cardiovascular or heart problems:		
Heart attack	☐	☐
Stroke	☐	☐
Angina	☐	☐
Heart failure	☐	☐
Swelling in your legs or feet (not caused by walking)	☐	☐
Heart arrhythmia (heart beating irregularly)	☐	☐
High blood pressure	☐	☐
Any other heart problem that you've been told about	☐	☐
6. Have you *ever had* any of the following cardiovascular or heart symptoms:		
Frequent pain or tightness in your chest	☐	☐
Pain or tightness in your chest during physical activity	☐	☐
Pain or tightness in your chest that interferes with your job	☐	☐
In the past 2 years, have you noticed your heart skipping or missing a beat	☐	☐
Heartburn or indigestion that is not related to eating	☐	☐
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:		
Breathing or lung problems	☐	☐
Heart trouble	☐	☐
Blood pressure	☐	☐
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, check (✓) here ☐ and go to question 9):		
Eye irritation	☐	☐
Skin allergies or rashes	☐	☐
Anxiety	☐	☐
General weakness or fatigue	☐	☐
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	☐	☐

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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Patient name	MHN	DOB	Age	Gender

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 *lost* vision in either eye (temporarily or permanently)	☐	☐
11. Do you *currently* have any of the following vision problems:		
Wear contact lenses	☐	☐
Wear glasses	☐	☐
Color blind	☐	☐
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:		
Difficulty hearing	☐	☐
Wear a hearing aid	☐	☐
Any other hearing or ear problem	☐	☐
14. Have you *ever had* a back injury	☐	☐
15. Do you *currently* have any of the following musculoskeletal problems:		
Weakness in any of your arms, hands, legs, or feet	☐	☐
Back pain	☐	☐
Difficulty fully moving your arms and legs	☐	☐
Pain or stiffness when you lean forward or backward at the waist	☐	☐
Difficulty fully moving your head up or down	☐	☐
Difficulty fully moving your head side to side	☐	☐
Difficulty bending at your knees	☐	☐
Difficulty squatting to the ground	☐	☐
Climbing a flight of stairs or a ladder carrying more than 25 lbs.	☐	☐
Any other muscle or skeletal problem that interferes with using a respirator	☐	☐

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	☐	☐
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	☐	☐
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	☐	☐
If yes, name the chemicals if you know them ______________________________		

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Patient name	MHN	DOB	Age	Gender

	Yes	No
3. Have you ever worked with any of the materials, or under any of the conditions listed below:		
Asbestos	☐	☐
Silica (e.g. in sandblasting)	☐	☐
Tungsten/Cobalt (e.g. grinding or welding this material)	☐	☐
Beryllium	☐	☐
Aluminum	☐	☐
Coal (e.g. mining)	☐	☐
Iron	☐	☐
Tin	☐	☐
Dusty environments	☐	☐
Any other hazardous exposures	☐	☐
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	☐	☐
If yes, were you exposed to biological or chemical agents (either in training or combat)	☐	☐
8. Have you ever worked on a hazardous materials team	☐	☐
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)	☐	☐
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	☐	☐
Canisters (e.g. gas masks)	☐	☐
Cartridges	☐	☐
11. How are you expected to use the respirator(s):		
Escape only (no rescue)	☐	☐
Emergency rescue only	☐	☐
Less than 5 hours per week	☐	☐
Less than 2 hours per day	☐	☐
2 to 4 hours per day	☐	☐

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.

______________________ Employee's signature

___ / ___ / ___ Date (month/day/year)

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