

Medical Evaluation Questionnaire – Respiratory Protection Program

This questionnaire is used in determining whether or not you have a medical condition that may affect your ability to wear a respirator. We anticipate being able to approve most people for respirator use based on this questionnaire alone. In some cases we may ask for more information. All medical information is considered confidential. When you have completed the questionnaire you may return it to the University Holzer Health Center. Fit testing is also required and will be done separately by the University Safety Office.

All Information Must Be Completed For Respirator Approval

University Safety Office (USO) Registration No.	
Recommended for RRP Medical Evaluation	
Title	
Signature →	Date

Can you Read? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Part A Section 1		
Today's Date Mon _____ Day _____ Yr _____	Have you worn a respirator before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type of respirator? _____ Did you experience any prior problems wearing a respirator? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name	Date of Birth <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number
Height	Weight	Tel
Best Time to Call:	Has your employer told you how to contact the health care professional who will review this questionnaire? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Title	Location	Supervisor _____ phone# _____
1. Respirator Type: APR – Air Purifying Respirator a <input type="checkbox"/> Dust/Mist Mask b <input type="checkbox"/> Half Face APR c <input type="checkbox"/> Full Face APR d <input type="checkbox"/> Powered Air Purifying Respirator e <input type="checkbox"/> Air Supplied Positive Pressure f <input type="checkbox"/> Self Contained Breathing Apparatus* * Weight _____ of SCBA Please complete additional questions in SCBA Questions Supplement.	2a. Respiratory Hazard a <input type="checkbox"/> Oxygen Deficiency b <input type="checkbox"/> Gas and Vapor Contaminant c <input type="checkbox"/> Particulate or Fiber Contaminant 2b. Recommended Medical Program(s) a <input type="checkbox"/> Respiratory Protection b <input type="checkbox"/> Asbestos c <input type="checkbox"/> Lead d <input type="checkbox"/> Pesticide/Herbicide e <input type="checkbox"/> Heat Tunnel f <input type="checkbox"/> _____	3. When using respirator, work is: a <input type="checkbox"/> Light b <input type="checkbox"/> Moderate c <input type="checkbox"/> Heavy
4a. Shifts (days) per week respirator is worn: a <input type="checkbox"/> Less than 1 shift b <input type="checkbox"/> 1-4 shifts c <input type="checkbox"/> Almost every shift	4b. Length of time respirator is worn during a shift (day): a <input type="checkbox"/> Less than 1 hour b <input type="checkbox"/> 1-5 hours c <input type="checkbox"/> 5-12 hours	5. Other Conditions: <input type="checkbox"/> Confined Spaces <input type="checkbox"/> Heat Stress <input type="checkbox"/> Exertion <input type="checkbox"/> Other _____ i.e. (imperious protective suits)

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

	k. Wheezing	Yes	No
	l. Wheezing that interferes with your job	Yes	No
	m. Chest pain when you breathe deeply	Yes	No
	n. Any other symptoms that you think may be related to lung problems	Yes	No
	5. Have you ever had any of the following cardiovascular or heart problems		
	a. Heart attack	Yes	No
	b. Stroke	Yes	No
	c. Angina	Yes	No
	d. Heart failure	Yes	No
	e. Swelling in your legs or feet (not caused by walking)	Yes	No
	f. Heart arrhythmia (heart beating irregularly)	Yes	No
	g. High blood pressure	Yes	No
	h. 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?		
	a. Frequent pain or tightness in your chest	Yes	No
	b. Pain or tightness in your chest during physical activity	Yes	No
	c. Pain or tightness in your chest that interferes with your job	Yes	No
	d. In the past two years, have you noticed your heart skipping or missing a beat	Yes	No
	e. Heartburn or indigestion that is not related to eating	Yes	No
	f. 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?		
	a. Breathing or lung problems	Yes	No
	b. Heart trouble	Yes	No
	c. Blood pressure	Yes	No
	d. 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:)		
	a. Eye irritation	Yes	No
	b. Skin allergies or rashes	Yes	No
	c. Anxiety	Yes	No
	d. General weakness or fatigue	Yes	No
	e. 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

SCBA Section	Questions 10 to 15 below must be answered by every employee who has been selected to use either a fullfacepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.		
	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		
	a. Wear contact lenses	Yes	No
	b. Wear glasses	Yes	No
	c. Color blind		
	d. 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	Yes	No
	a. Difficulty hearing		
	b. Wear a hearing aid	Yes	No
	c. 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		
	a. Weakness in any of your arms, hands, legs, or feet	Yes	No
	b. Back pain	Yes	No
	c. Difficulty fully moving your arms and legs	Yes	No
	d. Pain or stiffness when you lean forward or backward at the waist	Yes	No
	e. Difficulty fully moving your head up or down	Yes	No
	f. Difficulty fully moving your head side to side	Yes	No
	g. Difficulty bending at your knees	Yes	No
	h. Difficulty squatting to the ground	Yes	No
	i. Climbing a flight of stairs or a ladder carrying more than 25 lbs	Yes	No
	j. Any other muscle or skeletal problem that interferes with using a respirator	Yes	No

Part B	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	Yes	No
	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	Yes	No
	If "yes," name the chemicals if you know them:		
	3. Have you ever worked with any of the materials, or under any of the conditions, listed below		
	a. Asbestos		
	b. Silica (e.g., in sandblasting)	Yes	No
	c. Tungsten/cobalt (e.g., grinding or welding this material)	Yes	No
	d. Beryllium	Yes	No
	e. Aluminum		
	f. Coal (for example, mining):	Yes	No
	g. Iron	Yes	No

	h. Tin	Yes	No
	i. Dusty environments		
	j. Any other hazardous exposures	Yes	No
	If "yes," describe these 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?	Yes	No
	If "yes," were you exposed to biological or chemical agents (either in training or combat)	Yes	No
	8. Have you ever worked on a HAZMAT team?	Yes	No
	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)	Yes	No
	If "yes," name the medications if you know them		
	10. Will you be using any of the following items with your respirator(s)?	Yes	No
	a. HEPA Filters	Yes	No
	b. Canisters (for example, gas masks)	Yes	No
	c. Cartridges	Yes	No
	11. How often are you expected to use the respirator(s)		
	a. Escape only (no rescue)	Yes	No
	b. Emergency rescue only	Yes	No
	c. Less than 5 hours per week	Yes	No
	d. Less than 2 hours per day	Yes	No
	e. 2 to 4 hours per day	Yes	No
	f. Over 4 hours per day	Yes	No
	12. During the period you are using the respirator(s), is your work effort		

	<p>a. Light (less than 200 kcal per hour)</p> <p>Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.</p>	Yes	No
	<p>If "yes," how long does this period last during the average shift: _____ hrs. _____ mins</p>		
	<p>b. Moderate (200 to 350 kcal per hour):</p> <p>Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.</p>	Yes	No
	<p>If "yes," how long does this period last during the average shift: _____ hrs. _____ mins</p>		
	<p>c. Heavy (above 350 kcal per hour)</p> <p>Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).</p>	Yes	No
	<p>If "yes," how long does this period last during the average shift: _____ hrs. _____ mins</p>		
	<p>13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator</p>	Yes	No
	<p>If "yes," describe this protective clothing and/or equipment</p>		
	<p>14. Will you be working under hot conditions (temperature exceeding 77 deg. F)</p>	Yes	No
	<p>15. Will you be working under humid conditions</p>	Yes	No
	<p>16. Describe the work you'll be doing while you're using your respirator(s)</p>		
	<p>17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases)</p>		
	<p>18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s)</p>		
	<p>Name of the first toxic substance: _____ Estimated maximum exposure level per shift: _____ Duration of exposure per shift: _____</p>		

	Name of the second toxic substance: _____ Estimated maximum exposure level per shift: _____ Duration of exposure per shift: _____	
	Name of the third toxic substance: _____ Estimated maximum exposure level per shift: _____ Duration of exposure per shift: _____	
	The name of any other toxic substances that you'll be exposed to while using your respirator:	
	19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):	

Medical Department Use Only	Respirator Status for _____ has been: <input type="checkbox"/> Approved <input type="checkbox"/> Approved with Restrictions <input type="checkbox"/> Denied <input type="checkbox"/> More Information Needed
	<i>ATTENTION Holzer Health Center: Please return copy of <u>Respirator Status Section</u> of Medical Evaluation Questionnaire to Greg Peebles –University Safety Office.</i>
	Restrictions Remain
	Health Care Professional Signature →