

# Respirator Medical Evaluation Questionnaire

LC 5144 - TITLE 8

Bring this **COMPLETED** form to your appointment. Failure to bring a completed form will cause delay or postponement of your appointment.

## To the employer

Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

## To the employee

Can you read (mark 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, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

## PART A. SECTION 1. (MANDATORY)

The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date \_\_\_\_/\_\_\_\_/\_\_\_\_/ Name \_\_\_\_\_  
First Name Last Name
2. Your Age \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_
3. Sex  Male  Female
4. Your height \_\_\_\_\_ ft. \_\_\_\_\_ in.
5. Your weight \_\_\_\_\_ lbs.
6. Your Job title \_\_\_\_\_
7. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code) \_\_\_\_\_
8. The best time to phone you at this number \_\_\_\_\_
9. Has your employer told you how to contact the health care professional who will review this questionnaire?  No  Yes
10. Check the type of respirator you will use (you can check more than one category)
  - a. N, R, or P disposable respirator  filter-mask  non-cartridge type only
  - b. Other type  half- or full-facepiece  powered-air purifying  supplied-air  self-contained breathing apparatus
11. Have you worn a respirator?  No  Yes If "yes," what type(s) \_\_\_\_\_

## PART A. SECTION 2. (MANDATORY)

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please mark "yes" or "no").

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?  No  Yes
2. Have you ever had any of the following conditions?  No  Yes
  - a. Seizures (fits)  No  Yes
  - b. Diabetes (sugar disease)  No  Yes
  - c. Allergic reactions that interfere with your breathing  No  Yes
  - d. Claustrophobia (fear of closed-in places)  No  Yes
  - e. Trouble smelling odors  No  Yes

3. Have you ever had any of the following pulmonary or lung problems?
- |   |                             |                              |
|---|-----------------------------|------------------------------|
| a. Asbestosis   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| b. Asthma   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| c. Chronic bronchitis                                 | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| d. Emphysema  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| e. Pneumonia  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| f. Tuberculosis                                       | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| g. Silicosis  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| h. Pneumothorax (collapsed lung)                      | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| i. Lung cancer  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| j. Broken ribs  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| k. Any chest injuries or surgeries                    | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| l. Any other lung problem that you've been told about | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?
- |   |                             |                              |
|---|-----------------------------|------------------------------|
| a. Shortness of breath  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| c. Shortness of breath when walking with other people at an ordinary pace on level ground       | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| d. Have to stop for breath when walking at your own pace on level ground                        | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| e. Shortness of breath when washing or dressing yourself  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| f. Shortness of breath that interferes with your job  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| g. Coughing that produces phlegm (thick sputum)   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| h. Coughing that wakes you early in the morning   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| i. Coughing that occurs mostly when you are lying down  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| j. Coughing up blood in the last month  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| k. Wheezing   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| l. Wheezing that interferes with your job   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| m. Chest pain when you breathe deeply   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| n. Any other symptoms that you think may be related to lung problems                            | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
5. Have you **ever had** any of the following cardiovascular or heart problems?
- |  |                             |                              |
|--|-----------------------------|------------------------------|
| a. Heart attack  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| b. Stroke  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| c. Angina  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| d. Heart failure   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| e. Swelling in your legs or feet (not caused by walking) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| f. Heart arrhythmia (heart beating irregularly)          | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| g. High blood pressure                                   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| h. Any other heart problem that you've been told about   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
6. Have you **ever had** any of the following cardiovascular or heart symptoms?
- |  |                             |                              |
|--|-----------------------------|------------------------------|
| a. Frequent pain or tightness in your chest  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| b. Pain or tightness in your chest during physical activity                          | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| c. Pain or tightness in your chest that interferes with your job                     | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| d. In the past two years, have you noticed your heart skipping or missing a beat     | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| e. Heartburn or indigestion that is not related to eating                            | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| f. Any other symptoms that you think may be related to heart or circulation problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
7. Do you **currently** take medication for any of the following problems?
- |                               |                             |                              |
|-------------------------------|-----------------------------|------------------------------|
| a. Breathing or lung problems | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| b. Heart trouble              | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| c. Blood pressure             | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| d. Seizures (fits)            | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

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 )  Never used a respirator before
- |  |                             |                              |
|--|-----------------------------|------------------------------|
| a. Eye irritation  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| b. Skin allergies or rashes  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| c. Anxiety   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| d. General weakness or fatigue                                     | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| e. Any other problem that interferes with your use of a respirator | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire  No  Yes

Questions 10 to 15 below must be answered by every employee who has been selected to use a **full-face mask 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)  No  Yes
11. Do you **currently** have any of the following vision problems?
- |                                    |                             |                              |
|------------------------------------|-----------------------------|------------------------------|
| a. Wear contact lenses             | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| b. Wear glasses                    | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| c. Color blind                     | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| d. Any other eye or vision problem | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
12. Have you **ever** had an injury to your ears, including a broken ear drum?  No  Yes
13. Do you **currently** have any of the following hearing problems?
- |                                     |                             |                              |
|-------------------------------------|-----------------------------|------------------------------|
| a. Difficulty hearing               | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| b. Wear a hearing aid               | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| c. Any other hearing or ear problem | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
14. Have you **ever** had a back injury?  No  Yes
15. Do you **currently** have any of the following musculoskeletal problems?
- |   |                             |                              |
|---|-----------------------------|------------------------------|
| a. Weakness in any of your arms, hands, legs, or feet                           | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| b. Back pain  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| c. Difficulty fully moving your arms and legs                                   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| d. Pain or stiffness when you lean forward or backward at the waist             | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| e. Difficulty fully moving your head up or down                                 | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| f. Difficulty fully moving your head side to side                               | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| g. Difficulty bending at your knees   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| h. Difficulty squatting to the ground   | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.           | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| j. Any other muscle or skeletal problem that interferes with using a respirator | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

**PART B**

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.

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?  No  Yes
- 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?  No  Yes

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?  No  Yes  
 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	<input type="checkbox"/> No	<input type="checkbox"/> Yes
b. Silica (e.g., in sandblasting)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c. Tungsten/cobalt (e.g., grinding or welding this material)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
d. Beryllium	<input type="checkbox"/> No	<input type="checkbox"/> Yes
e. Aluminum	<input type="checkbox"/> No	<input type="checkbox"/> Yes
f. Coal (for example, mining)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
g. Iron	<input type="checkbox"/> No	<input type="checkbox"/> Yes
h. Tin	<input type="checkbox"/> No	<input type="checkbox"/> Yes
i. Dusty environments	<input type="checkbox"/> No	<input type="checkbox"/> Yes
j. Any other hazardous exposures	<input type="checkbox"/> No	<input type="checkbox"/> Yes

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?  No  Yes  
 If "yes," were you exposed to biological or chemical agents (either in training or combat)?  No  Yes

8. Have you ever worked on a HAZMAT team?  No  Yes

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)?  No  Yes  
 If "yes," name the medications if you know them \_\_\_\_\_

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters	<input type="checkbox"/> No	<input type="checkbox"/> Yes
b. Canisters (for example, gas masks)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c. Cartridges	<input type="checkbox"/> No	<input type="checkbox"/> Yes

11. How often are you expected to use the respirator(s) (mark "yes" or "no" for all answers that apply to you)?

a. Escape only (no rescue)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
b. Emergency rescue only	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c. Less than 5 hours <b>per week</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
d. Less than 2 hours <b>per day</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
e. 2 to 4 hours per day	<input type="checkbox"/> No	<input type="checkbox"/> Yes
f. Over 4 hours per day	<input type="checkbox"/> No	<input type="checkbox"/> Yes

12. During the period you are using the respirator(s), is your work effort

a. <b>Light</b> (less than 200 kcal per hour)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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If "yes," how long does this period last during the average shift \_\_\_\_\_ hrs. \_\_\_\_\_ mins.

*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.*

b. Moderate (200 to 350 kcal per hour)  No  Yes

If "yes," how long does this period last during the average shift \_\_\_\_\_ hrs. \_\_\_\_\_ mins.  
*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.*

c. **Heavy** (above 350 kcal per hour)  No  Yes

If "yes," how long does this period last during the average shift \_\_\_\_\_ hrs. \_\_\_\_\_ mins.  
*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.).*

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator?  No  Yes  
If "yes," describe this protective clothing and/or equipment \_\_\_\_\_

14. Will you be working under hot conditions (temperature exceeding 77 deg. F)?  No  Yes

15. Will you be working under humid conditions?  No  Yes

16. Describe the work you'll be doing while you're using your respirator(s)? \_\_\_\_\_

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases) \_\_\_\_\_

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)

Name of the first toxic substance \_\_\_\_\_

Estimated maximum exposure level per shift \_\_\_\_\_

Duration of exposure per shift \_\_\_\_\_

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)

\_\_\_\_\_  
\_\_\_\_\_