

Please forward results to St. Elizabeth Business Health, 200 Medical Village Drive, Edgewood, KY 41017

Respirator Medical Evaluation Questionnaire

To the employer:

- Answers to questions in Section 1 and to question 9 in section 2 part A do not require a medical examination.

To the employee: Can you read? 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)

- Every employee who selected to use any type of respirator must provide the following information –

1. Today's Date _____

2. Name: _____

3. Date of Birth: _____

4. Sex (check one): Female Male _____

5. Social Security #: _____

6. Height & Weight: _____ / _____

7. Company/Job Title: _____ Dept. _____

8. A phone number where you can be reached by our staff (include area code): () _____

9. The best time to reach you at this number: _____

10. Has your employer told you how to contact the Business Health Center (check one): Yes No

11. Check the type(s) of respirator you WILL USE (you can check more than 1) : N, R, or P disposable respirator (filter-mask non-cartridge type only)
 Other type of respirator (1/2 or full face, powered-air purifying, supplied-air, self-contained breathing apparatus)

12. Have you worn a respirator in the past? Yes No

If "yes" what type(s)? _____

Part A. Section 2. (Mandatory)

➤ Every employee selected to use any type of respirator must answer questions 1-9 below.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes No
2. Have you ever had any of the following conditions?
 - a) Seizures (fits)----- Yes No
 - b) Diabetes (sugar disease)----- Yes No
 - c) Allergic reactions that interfere with your breathing----- Yes No
 - d) Claustrophobia (fear of closed spaces)----- Yes No
 - e) Trouble Smelling Odors----- Yes No
3. Have you ever had any of the following pulmonary/lung problems?
 - a) Asbestosis----- Yes No
 - b) Asthma----- Yes No
 - c) Chronic Bronchitis----- Yes No
 - d) Emphysema----- Yes No
 - e) Pneumonia----- Yes No
 - f) Tuberculosis----- Yes No
 - g) Silicosis----- Yes No
 - h) Pneumothorax (collapsed lung)----- Yes No
 - i) Lung cancer----- Yes No
 - j) Broken ribs----- Yes No
 - k) Any chest injuries or surgeries----- 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/ lung illness?
 - a) Shortness of breath (SOB)----- Yes No
 - b) SOB when walking fast on level ground, up a slight hill or incline----- Yes No
 - c) SOB when walking with other people at an ordinary pace on level ground----- Yes No
 - d) Have to stop for breath when walking at you own pace on level ground----- Yes No
 - e) SOB when washing or dressing yourself----- Yes No
 - f) SOB 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) Swelling in your legs or feet (not caused by walking) ----- Yes No
 - c) Stroke----- Yes No
 - d) Heart arrhythmia (heart beating irregularly) ----- Yes No
 - e) Angina (chest pain) ----- Yes No
 - f) High blood pressure----- Yes No
 - g) Heart failure----- 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 2 years, have you noticed your heart skipping/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 from 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. Have you ever used a respirator before? (if yes continue, if no skip to question 9)
- a) When using a respirator in the past, have you ever had the following...?
 - 1) Eye irritation----- Yes No
 - 2) Skin allergies or rashes----- Yes No
 - 3) Anxiety----- Yes No
 - 4) General weakness or fatigue----- Yes No
 - 5) 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? ----- Yes No
- Questions 10 – 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 (SCBA). For employees who 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----- Yes No
 - d) Any other eye or vision problem----- Yes No
12. Have you ever had an injury to your ears, including a broken eardrum? ----- Yes No
13. Do you currently have any of the following hearing problems?
- a) Difficulty hearing----- Yes No
 - 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) Difficulty fully moving your head side to side----- Yes No
 - e) Difficulty bending at your knees----- Yes No
 - f) Difficulty squatting to the ground----- Yes No
 - g) Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs.----- Yes No
 - h) Any other muscle or skeletal problem that interferes with using a respirator---- Yes No