

University of Alabama

Respirator Medical Evaluation Questionnaire

To the employee: Can you read? (Circle one): Yes/No

Your employer must allow you to answer this questionnaire during normal work hours, or at a time and place that is convenient to you.

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).*

Name: _____ Date: _____

Phone #: (____) _____ the best time to reach you at this number: _____

Age (to nearest year): _____ Sex: Male? Female? Height: _____ Weight: _____

1. If you need to contact the health care professional who will review this questionnaire contact EHS (348-5905).
2. Have you worn a respirator? (circle one) Yes/ No
If yes, what type?

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 indicate yes or no).*

1. Do you currently smoke tobacco or have you in the last month? ___ Yes ___ No

2. Have you ever had any of the following conditions?

- | | |
|--|----------------|
| a) Seizures | ___ Yes ___ No |
| b) Diabetes | ___ Yes ___ No |
| c) Allergic reactions that interfere with your breathing | ___ Yes ___ No |
| d) Claustrophobia (fear of enclosed places) | ___ Yes ___ No |
| e) Trouble smelling odors | ___ Yes ___ No |

3. Have you ever had any of the following pulmonary or 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 problems that you have 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 incline __ Yes __ No
- c) Shortness of breath when walking at an ordinary pace with other people on level ground __ Yes __ No
- d) Stop for breath when walking at normal 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 __ Yes __ No
- h) Coughing that wakes you early in morning __ Yes __ No
- i) Coughing that occurs mostly when you are laying 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, heart problems or symptoms?
- a) Heart attack __ Yes __ No
- b) Stroke __ Yes __ No
- c) Angina __ Yes __ No
- d) heart failure __ Yes __ No
- e) Swelling in your legs and feet (not from walking) __ Yes __ No
- f) Heart beating irregularly __ Yes __ No
- g) High blood pressure __ Yes __ No
- h) Any other heart problem that you have been told about __ Yes __ No
- i) frequent pain or tightness in chest __ Yes __ No
- j) Pain or tightness in chest during physical activity __ Yes __ No
- k) Pain or tightness in your chest that interferes with your job __ Yes __ No
- l) In the past 2 years, have you noticed you heart skipping a beat __ Yes __ No
- m) Heartburn or indigestion not related to eating __ Yes __ No
- n) Any other symptoms that you think may be related to heart or circulation problems __ Yes __ No
6. 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 __ Yes __ No

If yes, name the medications if you know them: _____

7. If you've used a respirator, have you ever had any of the following problems?

* Never used a respirator _____

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 problems that interferes with your use of a respirator __ Yes __ No

8. Would you like to talk to the health care professional who will review this questionnaire? __ Yes __ No

ASSESSMENT- TO BE COMPLETED BY A NURSE OR PHYSICIAN

___ Employee is cleared to perform job duties with use of a respirator

___ Employee needs an evaluation by a physician

___ Other recommendations; _____

It should be noted that medical qualification for respirator use is dependent upon proper fit testing and instruction regarding use and maintenance of respiratory equipment.

Nurse or Physician signature

Date