University of Alabama

Respirator Medical Evaluation Questionnaire

To the employee: Can you read? 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? 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 No Yes 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 No Yes d) Emphysema Yes No e) Pneumonia Yes No f) Tuberculosis Yes No g) Silicosis Yes No h) Pneumothorax (collapsed lung) No Yes

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 lui	ng 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
1) 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
1) 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

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 have 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 Yes No	this question	naire?
ASSESSMENT- TO BE COMPLETED BY A NURSE OR PHY	SICIAN	
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 depend testing and instruction regarding use and maintenance of respiratory equ		er fit
Nurse or Physician signature Date		