SCOTTSDALE HEALTHCARE℠

Respiratory Protection Medical Evaluation Questionnaire

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☐ Other
_____

Company Name	**Supervisor/Manager**	**Phone** ( )	
Company Address	**City**	**State**	**Zip**
Employee Name	**Social Security Number**		
Employee Address	**City**	**State**	**Zip**

This questionnaire will help in determining your ability to wear a particulate respirator/mask. All medical information is considered confidential.

Section I

1. Today's date: _____
2. Your age (to nearest year): _____
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: (____)____
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? ☐ Yes ☐ No
10. Check the type of respirator you will use (you can check more than one category):

    ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only)

    ☐ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

12. Have you worn a respirator: ☐ Yes ☐ No If yes, what type(s): _____

Section II

	Yes	*No*	
1.	☐	☐	Do you currently smoke tobacco, or have you smoked tobacco in the last month?

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

	Yes	*No*	
a.	☐	☐	Seizures (fits)
b.	☐	☐	Diabetes (sugar disease)
c.	☐	☐	Allergic reactions that interfere with your breathing
d.	☐	☐	Claustrophobia (fear of closed-in places
e.	☐	☐	Trouble smelling odors

3. Have you **ever had** any of the following pulmonary or lung problems?

	Yes	*No*	
a.	☐	☐	Asbestosis
b.	☐	☐	Asthma
c.	☐	☐	Chronic bronchitis
d.	☐	☐	Emphysema
e.	☐	☐	Pneumonia
f.	☐	☐	Tuberculosis
g.	☐	☐	Silicosis
*h.	☐	☐	Pneumothorax (collapsed lung)
i.	☐	☐	Lung cancer
*j.	☐	☐	Broken ribs
*k.	☐	☐	Any chest injuries or surgeries
l.	☐	☐	Any other lung problem that you've been told about

4. Do you **currently have** any of the following symptoms of pulmonary or lung illness?

	Yes	*No*	
a.	☐	☐	Shortness of breath
b.	☐	☐	Shortness of breath when walking fast on level ground or walking up a slight hill or incline
c.	☐	☐	Shortness of breath when walking with other people at an ordinary pace on level ground
d.	☐	☐	Have to stop for breath when walking at your own pace on level ground
e.	☐	☐	Shortness of breath when washing or dressing yourself
f.	☐	☐	Shortness of breath that interferes with your job
g.	☐	☐	Coughing that produces phlegm (thick sputum)
h.	☐	☐	Coughing that wakes you early in the morning
i.	☐	☐	Coughing that occurs mostly when you are lying down
*j.	☐	☐	Coughing up blood in the last month
k.	☐	☐	Wheezing
l.	☐	☐	Wheezing that interferes with your job
m.	☐	☐	Chest pain when you breathe deeply
n.	☐	☐	Any other symptoms that you think may be related to lung problems

5. Have you **ever had** any of the following cardiovascular or heart problems?

	Yes	*No*	
*a.	☐	☐	Heart attack
b.	☐	☐	Stroke
*c.	☐	☐	Angina
d.	☐	☐	Heart failure
e.	☐	☐	Swelling in your legs or feet (not caused by walking)
f.	☐	☐	Heart arrhythmia (heart beating irregularly)
*g.	☐	☐	High blood pressure
h.	☐	☐	Any other heart problem that you have been told about

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

	Yes	*No*	
*a.	☐	☐	Frequent pain or tightness in your chest
b.	☐	☐	Pain or tightness in your chest during physical activity
c.	☐	☐	Pain or tightness in your chest that interferes with your job
d.	☐	☐	In the past two years, have you noticed your heart skipping or missing a beat
e.	☐	☐	Heartburn or indigestion that is not related to eating
f.	☐	☐	Any other symptoms that you think may be related to heart or circulation problems

7. Do you **currently take** medication for any of the following problems?

	Yes	*No*	
a.	☐	☐	Breathing or lung problems
b.	☐	☐	Heart trouble
c.	☐	☐	Blood pressure
d.	☐	☐	Seizures (fits)

8. If you have used a respirator, have you ever had any of the following problems? If you have never used a respirator, check the following space and go to next question: ☐ Never used a respirator

	Yes	*No*	
a.	☐	☐	Eye irritation
b.	☐	☐	Skin allergies or rashes
c.	☐	☐	Anxiety
d.	☐	☐	General weakness or fatigue
e.	☐	☐	Any other problem that interferes with your use of a respirator

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

	Yes	*No*
a.	☐	☐

The questions 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 have been selected to use other types of respirators, answering these questions is voluntary.

	Yes	*No*	
10.	☐	☐	Have you ever lost vision in either eye (temporarily or permanently)?

11. Do you currently have any of the following vision problems?

	Yes	*No*	
a.	☐	☐	Wear contact lenses
b.	☐	☐	Wear glasses
c.	☐	☐	Color blind
*d.	☐	☐	Any other eye or vision problem
12.	☐	☐	Have you ever had an injury to your ears, including a broken ear drum

13. Do you **currently have** any of the following hearing problems?

	Yes	*No*	
a.	☐	☐	Difficulty hearing
b.	☐	☐	Wear a hearing aid
*c.	☐	☐	Draining or painful ear
*d.	☐	☐	Ear infection
e.	☐	☐	Any other hearing or ear problem
14.	☐	☐	Have you ever had a back injury

15. Do you **currently have** any of the following musculoskeletal problems?

	Yes	*No*	
a.	☐	☐	Weakness in any of your arms, hands, legs, or feet
b.	☐	☐	Back pain
c.	☐	☐	Difficulty fully moving your arms and legs
d.	☐	☐	Pain or stiffness when you lean forward or backward at the waist
e.	☐	☐	Difficulty fully moving your head up or down
f.	☐	☐	Difficulty fully moving your head side to side
g.	☐	☐	Difficulty bending at your knees
h.	☐	☐	Difficulty squatting to the ground
i.	☐	☐	Climbing a flight of stairs or a ladder carrying more than 25 lbs.
j.	☐	☐	Any other muscle or skeletal problem that interferes with using a respirator

*Potential contraindications

Employee Name - Printed	Employee Signature	Date
Nurse Reviewing Medical Evaluation Name - Printed	Nurse Reviewing Medical Evaluation Signature	Date