

Patient name			
MHN	DOB	Age	Gender

Respiratory Medical Evaluation

Questionnaire

Statement of Understanding *(Read carefully before signing)*

This examination is being performed at the request of your employer or prospective employer to determine your ability to wear a respirator. Medical information obtained during this examination may be shared with the party requesting the examination with your release.

Please be aware that if you have an existing medical record at Marshfield Clinic, that record may be reviewed by the person doing the examination to confirm or clarify background health information.

It is important that the answers to the following questions are accurate and complete. An examination for respirator wear does not take the place of a complete physical. We will not treat you or prescribe treatment for you, however you will be notified if we find something abnormal. Please see your own doctor for your health care needs. At your request, we can release the results of your examination to your doctor.

Release of the results of your examination is controlled by law, including the Americans with Disabilities Act (ADA). If you have questions, direct them to the person doing the examination.

Name					Today's date (month/day/year)	
					/ /	
MHN	Age (to nearest year)	Sex:	Height	Weight	Date of birth (month/day/year)	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	ft. in.	lbs.	/ /	
Employer			Job title			

A phone number where you can be reached by the professionally licensed health care provider (PLHCP)

who reviews this questionnaire (include the area code) (_____) _____

The best time to call you at this number _____

Has your employer told you how to contact the PLHCP who will review this questionnaire: Yes No

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 (e.g. half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

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

This questionnaire is derived from the OSHA Respiratory Protection Standards 1910.134

**Respiratory Medical Evaluation
Questionnaire (Continued)**

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PART A: ALL RESPIRATORS

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (check "Yes" or "No".)

	Yes	No
1. Do you <i>currently</i> smoke tobacco or have you smoked tobacco in the last month	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you <i>ever had</i> any of the following conditions:		
Seizures (fits)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (sugar disease)	<input type="checkbox"/>	<input type="checkbox"/>
Allergic reactions that interfere with your breathing	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobia (fear of closed-in places)	<input type="checkbox"/>	<input type="checkbox"/>
Trouble smelling odors	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you <i>ever had</i> any of the following pulmonary or lung problems:		
Asbestosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Silicosis	<input type="checkbox"/>	<input type="checkbox"/>
Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/>
Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>
Broken ribs	<input type="checkbox"/>	<input type="checkbox"/>
Any chest injuries or surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Any other lung problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you <i>currently</i> have any of the following symptoms of pulmonary or lung illness:		
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath when walking fast on level ground or walking up a slight hill or incline	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath when washing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
Coughing that produces phlegm (thick sputum)	<input type="checkbox"/>	<input type="checkbox"/>
Coughing that wakes you early in the morning	<input type="checkbox"/>	<input type="checkbox"/>
Coughing that occurs mostly when you are lying down	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood in the last month	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain when you breathe deeply	<input type="checkbox"/>	<input type="checkbox"/>
Any other symptoms that you think may be related to lung problems	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory Medical Evaluation Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender
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	Yes	No
5. Have you ever had any of the following cardiovascular or heart problems:		
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>
Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
Swelling in your legs or feet (not caused by walking)	<input type="checkbox"/>	<input type="checkbox"/>
Heart arrhythmia (heart beating irregularly)	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Any other heart problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had any of the following cardiovascular or heart symptoms:		
Frequent pain or tightness in your chest	<input type="checkbox"/>	<input type="checkbox"/>
Pain or tightness in your chest during physical activity	<input type="checkbox"/>	<input type="checkbox"/>
Pain or tightness in your chest that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
In the past 2 years, have you noticed your heart skipping or missing a beat	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn or indigestion that is not related to eating	<input type="checkbox"/>	<input type="checkbox"/>
Any other symptoms that you think may be related to heart or circulation problems	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you currently take medication for any of the following problems:		
Breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Seizures (fits)	<input type="checkbox"/>	<input type="checkbox"/>
8. If you've used a respirator, have you ever had any of the following problems (If you've never used a respirator, check (✓) here <input type="checkbox"/> and go to question 9):		
Eye irritation	<input type="checkbox"/>	<input type="checkbox"/>
Skin allergies or rashes	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
General weakness or fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Any other problem that interferes with your use of a respirator	<input type="checkbox"/>	<input type="checkbox"/>
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire	<input type="checkbox"/>	<input type="checkbox"/>

I declare that my answers and statements are correct, complete, correctly recorded, and true to the best of my knowledge; and I understand that if employed, any false or misleading statements may result in termination at the employer's discretion.

Signature

Date (month/day/year)