Patient name			
MHN	DOB	Age	Gender

Respiratory Environmental Conditions

Questionnaire

Patient name (print)		MHN	Date of exam (month/day/year) / /
Birthdate (month/day/year)	Age	Sex: ☐ Male ☐ Female	
Employer UWSP - STEVENS POINT		Job title	

The employer MUST COMPLETE this form and attach it to the employee's Respiratory Medical Evaluation Questionnaire before the employee completes the history form. This will maintain confidentiality. You may also send this form to the professionally licensed health care provider (PLHCP) for review. All except the shaded area may be completed for a specific job and copied. The shaded area may then be completed for each individual.

1. Respirator type (include weight):
   - ☐ Air purifying (_____#)
     - ☐ Full
     - ☐ Half
   - ☐ Dust/Mist respirator (_____#)
   - ☐ Self-contained breathing apparatus (_____#)
   - ☐ Supplied air (_____#)
   - ☐ Other _____

2. Level of work required during respirator use:
   - ☐ Observation only (0 – 2 metabolic equivalents)
   - ☐ Light work – lifting, pushing, pulling 20 lbs. (2 – 4 metabolic equivalents)
   - ☐ Moderate work – lifting, pushing, pulling 21 – 45 lbs. (4 – 6 metabolic equivalents)
   - ☐ Heavy work – lifting, pushing, pulling 45 lbs. (6 – 8 metabolic equivalents)
   - ☐ Emergency rescue type work – presumed to be heavy (more than 8 metabolic equivalents)

3. Extent of usage:
   - ☐ Daily (hours per day _____)
   - ☐ Occasionally (days/week____; hours/week____)
   - ☐ Rescue use
   - ☐ Escape use

4. Special work considerations, describe:
   - ☐ Confined space
   - ☐ Extreme temperatures
   - ☐ Gloves
   - ☐ Height
   - ☐ Immediate danger to life or health (IDLH)
   - ☐ Noise greater than 85 decibel
   - ☐ Protective clothing
   - ☐ Safety glasses

5. Check/List any material the employee may/will be exposed to on this job and explain:

☐ Aluminum	☐ Cotton	☐ Inorganic arsenic pottery
☐ Asbestos	☐ Dust	☐ Iron
☐ Benzene	☐ Ethylene oxide	☐ Lead
☐ Beryllium	☐ Flax	☐ Silica
☐ Cadmium	☐ Formaldehyde	☐ Tin
☐ Chemicals	☐ Gases	☐ Tungsten
☐ Coal	☐ Hemp	☐ Vinyl chloride
☐ Cobalt		

☐ Other _____

Explain circumstances (i.e. exposure levels, permissible exposure limits, threshold limit valve) as needed

_____

_____

_____ Form completed by signature

_____ Print name

_____ / _____ / _____ Date (month/day/year)

_____ Provider signature/title

_____ Print name

_____ / _____ / _____ Date (month/day/year)

Additional copies to employer and employee