EMPLOYEE HEALTH SERVICES PARTICULATE RESPIRATOR MEDICAL EVALUATION

This questionnaire is used in determining whether or not you have a medical condition that may affect your ability to safely wear a respirator. Fit testing is also required and is done separately. All medical information is confidential.

The following information must be provided by every employee who has been selected to use any type of respirator (PLEASE PRINT).

Date:	Name:	University 2P Number:
Job Title:	Department:	Work Phone Number:
Age (to nearest year) / Sex (circle one): Male Female	Height in feet/inches	Weight in pounds

Has your employer told you how to contact the health care professional who will review this questionnaire? (circle one): 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)** ☐ **Other type (if you use (or plan to use) half or full face, or self-contained breathing apparatus, contact MyHealth@Work for respirator questionnaire supplement)**

The following information must be provided to the health care professional before he/she makes a recommendation concerning your ability to use a respirator:

1. **Duration and frequency of respirator use:** _____
2. **Expected physical work effort:** _____
3. **Additional protective clothing and equipment to be worn:** _____

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please Select "Y" or "N").

	Y	N
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?		
a. Seizures (fits)	Y	N
b. Diabetes (sugar disease)	Y	N
c. Allergic reactions that interfere with your breathing	Y	N
d. Claustrophobia (fear of closed-in places)	Y	N
e. Trouble smelling odors	Y	N
3. Have you ever had any of the following pulmonary or lung problems?		
a. Asbestosis	Y	N
b. Asthma	Y	N
c. Chronic Bronchitis	Y	N
d. Emphysema	Y	N
e. Pneumonia	Y	N
f. Tuberculosis	Y	N
g. Silicosis	Y	N
h. Pneumothorax (collapsed lung)	Y	N
i. Lung Cancer	Y	N
j. Broken Ribs	Y	N
k. Any chest injuries or surgeries	Y	N
l. Any other lung problem that you have been told about	Y	N
4. Do you currently have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath	Y	N
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	Y	N
c. Shortness of breath when walking with other people at an ordinary pace on level ground	Y	N
d. Have to stop for breath when walking at your own pace on level ground	Y	N
e. Shortness of breath when washing or dressing yourself	Y	N
f. Shortness of breath that interferes with your job	Y	N
g. Coughing that produces phlegm (thick sputum)	Y	N
h. Coughing that wakes you early in the morning	Y	N
i. Coughing that occurs mostly when you are lying down	Y	N
j. Coughing up blood in the last month	Y	N
k. Wheezing	Y	N
l. Wheezing that interferes with your job	Y	N
m. Chest pain when you breath deeply	Y	N
n. Any other symptoms that you think may be related to lung problems	Y	N
5. Have you ever had any of the following cardiovascular or heart problems?		
a. Heart Attack	Y	N
b. Stroke	Y	N
c. Heart Failure	Y	N
d. Swelling in your legs/ feet (not caused by walking)	Y	N
e. Hearth arrhythmia (heart beating irregularly)	Y	N
f. High blood pressure	Y	N
g. Any other heart problem that you have been told about	Y	N
6. Have you ever had any of the following cardiovascular or heart problems?		
a. Frequent pain or tightness in your chest	Y	N
b. Pain or tightness in your chest during physical activity	Y	N
c. Pain or tightness in your chest that interferes with your job	Y	N
d. In the past 2 years, have you noticed your heart skipping or missing a beat	Y	N
e. Heartburn or indigestion that is not related to eating	Y	N
f. Any other symptoms that you think might be related to heart or circulation problems	Y	N
7. Do you currently take medication for any of the following problems?		
a. Breathing or lung problems	Y	N
b. Heart trouble	Y	N
c. Blood Pressure	Y	N
d. Seizures (fits)	Y	N
8. If you've used a respirator, have you ever had any of the following problems?		
a. Eye Irritation	Y	N
b. Skin Allergies or Rashes	Y	N
c. Anxiety	Y	N
d. General Weakness or Fatigue	Y	N
e. Any other problem that interferes with your use of a respirator	Y	N
9. Would you like to talk to the health care professional who will review this questionnaire about your answers on this questionnaire?	Y	N

Employee Signature **Date**

μ **Approved**	μ **Denied**	μ **Approved w/restrictions**	μ **More information needed**

Remarks:

Physician/Nurse Signature	**Date**