RightSourcing by Magnit

Respirator Medical Evaluation Questionnaire

Section 1. (Mandatory)

The following information must be provided by every Worker who has been selected to use any type of respirator.	
1. Today's Date:	
2. Your Name:	
3. Your Age (to nearest year):	
4. Sex (check one):	☐ **Male** ☐ **Female**
5. Your height:	_____ **feet** _____ **Inches**
6. Your weight:	_____ **lbs.**
7. Your job title:	_
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the area code):	
9. Has your employer told you how to contact the health care professional who will review this questionnaire? (Check one):	☐ **Yes** ☐ **No**
10. Have you worn a respirator? (Check one):	☐ **Yes** ☐ **No**

Section 2: (Mandatory)

Questions 1 through 9 below must be answered by every worker who has been selected to use any type of respirator
(Please check 'yes' or 'no').

	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?		
a. Seizures		
b. Diabetes (sugar disease)		
c. Allergic reactions that interfere with your breathing		
d. Claustrophobia (fear of closed-in places)		
e. Trouble smelling orders		
3. Have you ever had any of the following pulmonary or lung problems?		
a. Asbestosis		
b. Asthma		
c. Chronic bronchitis		
d. Emphysema		
e. Pneumonia		
f. Tuberculosis		
g. Pneumothorax (collapsed lung)		
h. Lung Cancer		
i. Broken ribs		
j. Any chest injuries or surgeries		
k. Any other lung problem that you've been told about		

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Continued from previous page…	Yes	No
4. Do you currently have any of the following symptoms of pulmonary or lung illness?		
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 space 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. Chest pain when you breathe deeply		
m. 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?		
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 you have been told about		
6. Have you ever had any of the following cardiovascular or heart symptoms?		
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 (2) 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?		
a. Breathing or lung problems		
b. Heart trouble		
c. Blood pressure		
d. Seizures		
8. If you have used a respirator, have you ever had any of the following problems? **(If you never used a respirator, check 'no' and go to question 9)**		
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. Healthcare Provider Evaluation: Is the individual able to be undergo Mask Fit testing? If no, please state if an accommodation is needed?		

Worker's Signature:		**Date:**	
Healthcare Provider Signature:		**Date:**	