MEDICAL QUESTIONNAIRE FOR RESPIRATOR USERS
Western Kentucky University

The medical evaluation is to help determine a worker's ability to use a respirator. Using a respirator may place a physiological burden on an employee's health or increase the risk of illness, injury, or death. The medical evaluation must be completed and evaluated by a physician or a licensed health care professional before an employee is fit tested or required to use a respirator. All answers are confidential between you and the medical physician.

All respirator users must complete the questions in this section of the questionnaire.
Check one or all that apply

Complete below

Name:				Date:
Your Job Title:				Manager:
Check one: Male		Female		Weight:
Date of Birth:				
Height:				
Phone:				

Department Name		***Type of Respirator (check one or all that apply)***	
		N, R, P, Filtering facepiece	
		Half face elastomeric	
		Full face elastomeric	
		I have worn a respirator before	

	YES	**NO**
Do you currently smoke tobacco?		
Have you smoked tobacco in the last month?		

Have you ever had any of the following conditions?	**YES**	**NO**
Seizures?		
Diabetes?		
Allergic reactions that interfere with breathing?		
Claustrophobia?		
Trouble smelling odors?		
Asbestosis?		
Asthma?		
Chronic Bronchitis?		

	YES	**NO**
Emphysema?		
Pneumonia?		
Tuberculosis?		
Silicosis?		
Pneumothorax (collapsed lung)?		
Lung cancer?		
Broken ribs?		
Any chest injuries or surgeries?		

Any other lung problems?		

Do you currently have shortness of breath:	**YES**	**NO**
When walking fast on level ground or up a slight hill?		
When walking at an ordinary pace on level ground?		
When washing or dressing yourself?		
That interferes with your job?		

Do you currently have a cough that:	**YES**	**NO**
Produces phlegm?		
Wakes you up early in the morning?		
Occurs when you are lying down?		
Produces blood		

Do you currently have?	**YES**	**NO**
Wheezing sensations?		
Chest pain when you breathe deeply?		
Symptoms that might be related to lung problems?		

Have you ever had any of the following?	**YES**	**NO**
Heart attack?		
Stroke?		
Angina?		
Heart failure?		
Swelling in legs or feet (not caused by walking)?		
Heart arrhythmia?		
High blood pressure?		
Any other heart problems?		
Frequent pain or tightness in the chest?		
Chest pain or tightness during physical activity?		
Heart skipping or missing beats?		
Heartburn or indigestions that is not related to eating?		

Do you currently take medication for?	**YES**	**NO**
Breathing or lung problems?		
Heart trouble?		
Blood pressure?		
Seizures?		

Check one or all that apply

How often do you use a reaspirator?	1-5 times a year		1-5 in a month		Emergency use only	
Duration respirator worn	1-5 hours/ use		5-8 hours/use		Less than an hour /use	
Expected physical work effort	Light		Moderate		Heavy & intense	
Temperature and humidity extremes	Indoors air conditioned		Indoors, fresh air only		Hot, humid outdoors, confined space	
Other PPE worn with	Tyvek suit		Goggles		Head covering	

respirator						

Answer theses question only if you have previously used a respirator. If you have never used a respirator, go to the next section.

Have you ever had these problems while using a respirator?	**YES**	**NO**
Eye irritation		
Skin allergies or rashes		
Anxiety		
General weakness or fatigue		

The following questions must be answered by employees who will be using a full-face piece respirator. Half face respirators or dust mask users may answer voluntarily**.**

	YES	**NO**
Have you lost vision in either eye?		
Do you wear contact lenses?		
Do you wear glasses?		
Are you color blind?		
Do you have any other eye problems?		

Have you ever had an ear injury (including a broken ear drum?		
Do you have difficulty hearing?		
Do you wear a hearing aid?		
Do you have any hearing or ear problem?		

Have you ever had	**YES**	**NO**
A back injury?		
Back pain?		
Weakness in your arms, hand, legs or feet?		
Difficulty fully moving your arms & legs?		
Pain or stiffness at the waist when you lean forward or backward?		
Difficulty moving your head up or down?		
Difficulty moving your head from side to side?		
Difficulty bending your knees?		
Difficulty squatting?		
Difficulty climbing carrying more than 25 lbs?		
Other muscle or skeletal problems that interfere with using a respirator?		

Any of the following questions may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

	YES	NO
Do you work in a place that has lower than normal amounts of oxygen?		
Do you have feelings of dizziness, shortness of breath, or pounding in your chest?		
Other symptoms when working under these conditions?		

At work or home	YES	NO
Have you ever been exposed to hazardous solvents?		
Have you ever been exposed to hazardous airborne chemicals?		
Have you come into skin contact with hazardous chemicals?		
Name the chemicals if you know them:		

Have you ever worked with any of the materials, or under any of the conditions listed?	YES	NO
Asbestos		
Silica		
Tungsten/cobalt (grinding or welding this material)		
Beryllium		
Aluminum		
Coal		
Iron		
Tin		
Dusty environments		
Any other hazardous exposures		
If yes describe these exposures:		

List any second jobs or side businesses you have:
List your previous occupations:
List your current and previous hobbies:

	YES	NO
If you were in the military were you exposed to biological or chemical agents?		
Have you ever worked on a HAZMAT team?		

List any medications you may be taking (including over the counter medications).