



Respiratory Protection Program

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Administrator Instructions:

You must tell your employee/student how to deliver or send the completed questionnaire to the health care provider you have selected.

- You must not review employees'/student's questionnaires.
- If you are a student return the questionnaire to Student Health Services.
- If you are an employee return the questionnaire to Occ Doc.

Health Care Provider's Instructions:

- Review the information in this questionnaire and any additional information provided to you by the administrator.
- You may add questions to this questionnaire at your discretion; however, questions in Parts 1-3 may not be deleted or substantially altered.
- Follow-up evaluation is required for any positive response to questions 1-8 in Part 2, or questions 1-6 in Part 3. This might include: phone consultations to evaluate positive responses, medical tests, and diagnostic procedures.
- When your evaluation is complete, send a copy of your written recommendation to the administrator and potential participant.

Participant Information and Instructions:

- Your administrator must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you.
- Your administrator or supervisor must not look at or review your answers at any time.

For questions, please contact Environmental Health and Safety:

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Conway, SC 29528-6054

843-349-2770

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Part 1. Background Information

ALL potential respirator wearers must complete this part. Please print legibly.

1. Today's date: _____
2. Your name: _____
3. CCU ID #: _____
4. Your age (to nearest year): _____
5. Gender (circle one): Male / Female
6. Your height: _____ ft. _____ in.
7. Your weight: _____ lbs.
8. Your title: _____
9. A phone number where you can be reached by the health care professional who reviews this questionnaire (include area code): _____
10. The best time to call you at this number: _____ a.m. _____ p.m.
11. Has your administrator told you how to contact the health care professional who will review this questionnaire?
 Yes
 No
12. Check the type of respirator(s) you will be using:
 N, R, or P filtering facepiece respirator (for example, a dust mask, OR an N95 filtering facepiece respirator)
 Half mask
 Full facepiece mask
 Helmet hood
 Escape
 Non-powered cartridge or canister
 Powered air-purifying cartridge respirator (PAPR)
 Supplied-air or Air-line
 Self-contained breathing apparatus (SCBA): Demand or Pressure demand
 Other: _____
13. Have you previously worn a respirator?
 Yes
 No
14. If "yes," describe what type(s): _____

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ALL participants must complete this section. Please check "Yes" or "No."

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?
 - Yes
 - No
2. Have you ever had any of the following conditions?
 - a. Seizures (fits):
 - Yes
 - No
 - b. Diabetes (sugar disease):
 - Yes
 - No
 - c. Allergic reactions that interfere with your breathing:
 - Yes
 - No
 - d. Claustrophobia (fear of closed-in places):
 - Yes
 - No
 - e. Trouble smelling odors:
 - Yes
 - No
3. Have you ever had any of the following pulmonary or lung problems?
 - a. Asbestosis:
 - Yes
 - No
 - b. Asthma:
 - Yes
 - No
 - c. Chronic bronchitis:
 - Yes
 - No
 - d. Emphysema:
 - Yes
 - No
 - e. Pneumonia:
 - Yes
 - No
 - f. Tuberculosis:
 - Yes
 - No
 - g. Silicosis:
 - Yes
 - No
 - h. Pneumothorax (collapsed lung):
 - Yes
 - No
 - i. Lung cancer:
 - Yes
 - No



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- j. Broken ribs:
 - Yes
 - No
- k. Any chest injuries or surgeries:
 - Yes
 - No
- l. Any other lung problem that you have been told about:
 - Yes
 - No
- 4. Do you currently have any of the following symptoms of pulmonary or lung illness?
 - a. Shortness of breath:
 - Yes
 - No
 - b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:
 - Yes
 - No
 - c. Shortness of breath when walking with other people at an ordinary pace on level ground:
 - Yes
 - No
 - d. Have to stop for breath when walking at your own pace on level ground:
 - Yes
 - No
 - e. Shortness of breath when washing or dressing yourself:
 - Yes
 - No
 - f. Shortness of breath that interferes with your job:
 - Yes
 - No
 - g. Coughing that produces phlegm (thick sputum):
 - Yes
 - No
 - h. Coughing that wakes you early in the morning:
 - Yes
 - No
 - i. Coughing that occurs mostly when you are lying down:
 - Yes
 - No
 - j. Coughing up blood in the last month:
 - Yes
 - No
 - k. Wheezing:
 - Yes
 - No
 - l. Wheezing that interferes with your job:
 - Yes
 - No
 - m. Chest pain when you breathe deeply:
 - Yes
 - No
 - n. Any other symptoms that you think may be related to lung problems:
 - Yes
 - No

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5. Have you ever had any of the following cardiovascular or heart problems?
- a. Heart attack:
 - Yes
 - No
 - b. Stroke:
 - Yes
 - No
 - c. Angina:
 - Yes
 - No
 - d. Heart failure:
 - Yes
 - No
 - e. Swelling in your legs or feet (not caused by walking):
 - Yes
 - No
 - f. Heart arrhythmia (heart beating irregularly):
 - Yes
 - No
 - g. High blood pressure:
 - Yes
 - No
 - h. Any other heart problem that you have been told about:
 - Yes
 - No
6. Have you ever had any of the following cardiovascular or heart symptoms?
- a. Frequent pain or tightness in your chest:
 - Yes
 - No
 - b. Pain or tightness in your chest during physical activity:
 - Yes
 - No
 - c. Pain or tightness in your chest that interferes with your job:
 - Yes
 - No
 - d. In the past 2 years, have you noticed your heart skipping or missing a beat:
 - Yes
 - No
 - e. Heartburn or indigestion that isn't related to eating:
 - Yes
 - No
 - f. Any other symptoms that you think may be related to heart or circulation problems:
 - Yes
 - No
7. Do you currently take medication for any of the following problems?
- a. Breathing or lung problems:
 - Yes
 - No
 - b. Heart trouble:
 - Yes
 - No



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- c. Blood pressure:
 - Yes
 - No
- d. Seizures (fits):
 - Yes
 - No
- 8. If you have used a respirator, have you ever had any of the following problems? (If you have never used a respirator, check the following space and go to question 9.)
 - a. Eye irritation:
 - Yes
 - No
 - b. Skin allergies or rashes:
 - Yes
 - No
 - c. Anxiety:
 - Yes
 - No
 - d. General weakness or fatigue:
 - Yes
 - No
 - e. Any other problem that interferes with your use of a respirator?
 - Yes
 - No
- 9. Would you like to talk about this questionnaire with a health care professional who has reviewed this questionnaire?
 - Yes
 - No



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Part 3. Additional Questions for Users of Full-Facepiece Respirators or SCBAs.

Please check "Yes" or "No."

1. Have you ever lost vision in either eye (temporarily or permanently):
 - Yes
 - No
2. Do you currently have any of these vision problems?
 - a. Need to wear contact lenses:
 - Yes
 - No
 - b. Need to wear glasses:
 - Yes
 - No
 - c. Color blindness:
 - Yes
 - No
 - d. Any other eye or vision problem:
 - Yes
 - No
3. Have you ever had an injury to your ears, including a broken ear drum:
 - Yes
 - No
4. Do you currently have any of these hearing problems?
 - a. Difficulty hearing:
 - Yes
 - No
 - b. Need to wear a hearing aid:
 - Yes
 - No
 - c. Any other hearing or ear problem
 - Yes
 - No
5. Have you ever had a back injury?
 - Yes
 - No
6. Do you currently have any of the following musculoskeletal problems?
 - a. Weakness in any of your arms, hands, legs, or feet:
 - Yes
 - No
 - b. Back pain:
 - Yes
 - No
 - c. Difficulty fully moving your arms and legs:
 - Yes
 - No
 - d. Pain or stiffness when you lean forward or backward at the waist:
 - Yes
 - No
 - e. Difficulty fully moving your head up or down:
 - Yes
 - No



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- f. Difficulty fully moving your head side to side:
 - Yes
 - No
- g. Difficulty bending at your knees:
 - Yes
 - No
- h. Difficulty squatting to the ground:
 - Yes
 - No
- i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs:
 - Yes
 - No
- j. Any other muscle or skeletal problem that interferes with using a respirator:
 - Yes
 - No

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Complete questions in this part only if your administrator's health care provider says they are necessary.

1. In your present position, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen?

- Yes
 No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you are working under these conditions?

- Yes
 No

2. Have you ever been exposed (at work or home) to hazardous solvents, hazardous airborne chemicals (such as, gases, fumes, or dust), or have you come into skin contact with hazardous chemicals?

- Yes
 No

If "yes," name the chemicals, if you know them: _____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

a. Asbestos?

- Yes
 No

b. Silica (for example, in sandblasting)?

- Yes
 No

c. Tungsten/cobalt (for example, grinding or welding this material)?

- Yes
 No

d. Beryllium?

- Yes
 No

e. Aluminum?

- Yes
 No

f. Coal (for example, mining)?

- Yes
 No

g. Iron?

- Yes
 No

h. Tin?

- Yes
 No

i. Dusty environments?

- Yes
 No

j. Any other hazardous exposures?

- Yes
 No

If "yes," describe these exposures: _____

4. List any second jobs or side businesses you have: _____
5. List your previous occupations: _____
6. List your current and previous hobbies: _____

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7. Have you been in the military services?

- Yes
- No

If "yes," were you exposed to biological or chemical agents (either in training or combat)?

- Yes
- No

8. Have you ever worked on a HAZMAT team?

- Yes
- No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)?

- Yes
- No

If "yes," name the medications if you know them: _____

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters:

- Yes
- No

b. Canisters (for example, gas masks):

- Yes
- No

c. Cartridges:

- Yes
- No

11. How often are you expected to use the respirator(s)?

a. Escape-only (no rescue):

- Yes
- No

b. Emergency rescue only:

- Yes
- No

c. Less than 5 hours per week:

- Yes
- No

d. Less than 2 hours per day:

- Yes
- No

e. Two to 4 hours per day:

- Yes
- No

f. Over 4 hours per day:

- Yes
- No



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12. During the period you are using the respirator(s), is your work effort:

a. Light (less than 200 kcal per hour):

- Yes
- No

If "yes," how long does this period last during the average shift: _____hrs. _____mins.

Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.

b. Moderate (200 to 350 kcal per hour):

- Yes
- No

If "yes," how long does this period last during the average shift: _____hrs. _____mins.

Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

c. Heavy (above 350 kcal per hour):

- Yes
- No

If "yes," how long does this period last during the average shift: _____hrs. _____mins.

Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.)