☐ North	2724 Greenwood Rd	Shreveport, LA 71109	
☐ Pierremont	1666 E Bert Kouns, Ste 125	Shreveport, LA 71105	
☐ Bossier	2300 Hospital Drive, Ste 360	Bossier City, LA 71111	

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

(OSHA Standards - 29 CFR; Appendix C to Sec. 1910.134)

To the employer: ________________________________
Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee:
Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers. Your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory)
The following information must be provided by every employee who has been selected to use any type of respirator. (please print)

Date: ____________

Name: ____________________________ Patient ID: ____________ DOB: ___________

Age: _____ Sex: ☐ M ☐ F Height: ______ (feet) _____ (inches) Weight: ________

Job Title: ________________________________ Job not in list: ________________________________

A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): ______________________

The best time to phone you at this number: ________________________________

Has your employer told you how to contact the health care professional who reviews this questionnaire? ☐ 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, non-cartridge type only).

☐ Other type (e.g., half or full-face piece type, powered-air purifying (PAPR), supplied-air, self-contained breathing apparatus (SCBA)).

Have you worn a respirator? ☐ Yes ☐ No
If "yes", what type(s):

___

Name: ______________________________ Patient ID: ____________ DOB: __________________

Part A. Section 2. (Mandatory)
Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator.

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
   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 or 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 breath deeply ☐ Yes ☐ No
   n. Any other symptoms that you think may be related to lung problems ☐ Yes ☐ No

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 problems 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 is not related to eating ☐ Yes ☐ No
   f. Any other symptoms that you think may be related to heart or circulation problems ☐ Yes ☐ No

Name: ______________________________ Patient ID: _____________ DOB: ___________________

Part A. Section 2. (Mandatory - continued)

7. Do you *currently* take medication for any of the following problems?
   - a. Breathing or lung problems ☐ Yes ☐ No
   - b. Heart trouble ☐ Yes ☐ No
   - 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?
   - 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 speak with the reviewing health care professional about your answers to this questionnaire? ☐ Yes ☐ No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is *voluntary*.

10. Have you *ever lost* vision in either eye temporarily or permanently? ☐ Yes ☐ No

11. Do you *currently* have any of the following vision problems?
    - a. Wear contact lenses ☐ Yes ☐ No
    - b. Wear glasses ☐ Yes ☐ No
    - c. Color blind ☐ Yes ☐ No
    - d. Any other eye or vision problem ☐ Yes ☐ No

12. Have you *ever had* an injury to your ears, including a broken ear drum? ☐ Yes ☐ No

13. Do you *currently* have any of the following hearing problems?
    - a. Difficulty hearing ☐ Yes ☐ No
    - b. Wear a hearing aid ☐ Yes ☐ No
    - c. Any other hearing or ear problem ☐ Yes ☐ No

14. Have you *ever had* a back injury? ☐ Yes ☐ No

15. 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
    - 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. 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

Examiner Comments:

Name: ______________________________ Patient ID: ____________ DOB: __________________

Part B. Discretionary Questions

1. In your present job 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. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., 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 (e.g., sandblasting) ☐ Yes ☐ No
   c. Tungsten/cobalt (e.g., grinding or welding this material) ☐ Yes ☐ No
   d. Beryllium ☐ Yes ☐ No
   e. Aluminum ☐ Yes ☐ No
   f. Coal (e.g., 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:

   ____

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 (e.g., gas masks) ☐ Yes ☐ No
    c. Cartridges ☐ Yes ☐ No

Name: ______________________ Patient ID: __________ DOB: ________________

Part B. (Discretionary questions - continued)

11. How often are you expected to use the respirator(s)? (check all answers that apply to you)
    a. Escape only (no rescue duties) ☐ Yes ☐ No
    b. Emergency rescue only ☐ Yes ☐ No
    c. Less than 5 hrs. per week ☐ Yes ☐ No
    d. Less than 2 hrs. per day ☐ Yes ☐ No
    e. 2 to 4 hrs. per day ☐ Yes ☐ No
    f. over 4 hrs. per day ☐ Yes ☐ No

12. During the period you are using your 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.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you are using your respirator? ☐ Yes ☐ No

    If "yes," describe this protective clothing and/or equipment:

    ____

14. Will you be working under hot conditions (temperature exceeding 77 deg. F)? ☐ Yes ☐ No
15. Will you be working under humid conditions? ☐ Yes ☐ No
16. Describe the work you will be doing while using your respirator(s):

    ____

17. Describe any special or hazardous conditions you might encounter when you are using your respirator(s) (for example, confined spaces, life-threatening gases):

    ____

18. Provide the following information, if you know it, for each toxic substance that you will be exposed to when using your respirator(s):
    Name of the first toxic substance:______________________________
    Estimated maximum exposure level per shift: ______________________________
    Duration of exposure per shift:______________________________
    Name of the second toxic substance:______________________________
    Estimated maximum exposure level per shift: ______________________________
    Duration of exposure per shift:______________________________
    Name of the third toxic substance:______________________________
    Estimated maximum exposure level per shift: ______________________________
    Duration of exposure per shift:______________________________

    Name of any other toxic substances that you will be exposed to while using your respirator(s):

    ____

19. Describe any special responsibilities you will have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):

    ____