

**LAKE HEALTH  
OCCUPATIONAL SERVICES RESPIRATOR MEDICAL  
EVALUATION QUESTIONNAIRE PART A Page 1 of 3**

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**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:** \_\_\_\_\_ **Company Name:** \_\_\_\_\_

**Can you read?**  Y  N **Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

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, and 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).**

1. Today's date: \_\_\_\_\_
2. Your name: \_\_\_\_\_
3. Your age (to nearest year): \_\_\_\_\_
4. Sex:  M  F
5. Your height: \_\_\_\_\_ ft. \_\_\_\_\_ in.
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 area code): \_\_\_\_\_
9. The best time to phone you at this number: \_\_\_\_\_
10. Has your employer told you how to contact the health care professional who will review this questionnaire?  Y  N
11. Check the type of respirator you will use (you can check more than one category):
  - a.  N, R or P disposable respirator (filter-mask, non-cartridge type only).
  - b.  Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator?  Y  N If yes, what type(s): \_\_\_\_\_

**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:.....  Y  N
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



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3. Have you ever had any of the following pulmonary or lung problems?
- |  |   |  |   |
|--|---|--|---|
| a. Asbestosis: .....                     | <input type="checkbox"/> Y <input type="checkbox"/> N | b. Asthma:.....  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| c. Chronic bronchitis: .....             | <input type="checkbox"/> Y <input type="checkbox"/> N | d. Emphysema:.....                                       | <input type="checkbox"/> Y <input type="checkbox"/> N |
| e. Pneumonia:.....                       | <input type="checkbox"/> Y <input type="checkbox"/> N | f. Tuberculosis: .....                                   | <input type="checkbox"/> Y <input type="checkbox"/> N |
| g. Silicosis: .....                      | <input type="checkbox"/> Y <input type="checkbox"/> N | h. Pneumothorax (collapsed lung):.....                   | <input type="checkbox"/> Y <input type="checkbox"/> N |
| i. Lung Cancer: .....                    | <input type="checkbox"/> Y <input type="checkbox"/> N | j. Broken ribs: .....                                    | <input type="checkbox"/> Y <input type="checkbox"/> N |
| k. Any chest injuries or surgeries:..... | <input type="checkbox"/> Y <input type="checkbox"/> N | l. Any other lung problems that you've been told about?. | <input type="checkbox"/> Y <input type="checkbox"/> N |
4. Do you currently have any of the following symptoms of pulmonary or lung illness?
- |  |   |
|--|---|
| a. Shortness of breath: .....  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N |
| c. Shortness of breath when walking with other people at an ordinary pace on level ground? .....       | <input type="checkbox"/> Y <input type="checkbox"/> N |
| d. Have to stop for breath when walking at your own pace on level ground: .....                        | <input type="checkbox"/> Y <input type="checkbox"/> N |
| e. Shortness of breath when washing or dressing yourself: .....  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| f. Shortness of breath that interferes with your job: .....  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| g. Coughing that produces phlegm (thick sputum): .....   | <input type="checkbox"/> Y <input type="checkbox"/> N |
| h. Coughing that wakes you early in the morning: .....   | <input type="checkbox"/> Y <input type="checkbox"/> N |
| i. Coughing that occurs mostly when you are lying down: .....  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| j. Coughing up blood in the last month: .....  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| k. Wheezing: .....   | <input type="checkbox"/> Y <input type="checkbox"/> N |
| l. Wheezing that interferes with your job: .....   | <input type="checkbox"/> Y <input type="checkbox"/> N |
| m. Chest pain when you breathe deeply: .....   | <input type="checkbox"/> Y <input type="checkbox"/> N |
| n. Any other symptoms that you think may be related to lung problems:.....                             | <input type="checkbox"/> Y <input type="checkbox"/> N |
5. Have you ever had any of the following cardiovascular or heart problems:
- |  |   |                        |   |
|--|---|------------------------|---|
| a. Heart attack: .....   | <input type="checkbox"/> Y <input type="checkbox"/> N | b. Stroke: .....       | <input type="checkbox"/> Y <input type="checkbox"/> N |
| c. Angina:.....  | <input type="checkbox"/> Y <input type="checkbox"/> N | d. Heart failure:..... | <input type="checkbox"/> Y <input type="checkbox"/> N |
| e. Swelling in your legs or feet (not caused by walking) ..... | <input type="checkbox"/> Y <input type="checkbox"/> N |                        |   |
| f. Heart arrhythmia (heart beating irregularly):.....          | <input type="checkbox"/> Y <input type="checkbox"/> N |                        |   |
| g. High blood pressure:.....                                   | <input type="checkbox"/> Y <input type="checkbox"/> N |                        |   |
| h. Any other heart problem that you've been told about: .....  | <input type="checkbox"/> Y <input type="checkbox"/> N |                        |   |
6. Have you ever had any of the following cardiovascular or heart symptoms?
- |  |   |
|--|---|
| a. Frequent pain or tightness in your chest:.....  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| b. Pain or tightness in your chest during physical activity:.....                          | <input type="checkbox"/> Y <input type="checkbox"/> N |
| c. Pain or tightness in your chest that interferes with your job:.....                     | <input type="checkbox"/> Y <input type="checkbox"/> N |
| d. In the past two years, have you noticed your heart skipping or missing a beat:.....     | <input type="checkbox"/> Y <input type="checkbox"/> N |
| e. Heartburn or indigestion that is not related to eating:.....                            | <input type="checkbox"/> Y <input type="checkbox"/> N |
| f. Any other symptoms that you think may be related to heart or circulation problems:..... | <input type="checkbox"/> Y <input type="checkbox"/> N |
7. Do you currently take medication for any of the following problems?
- |                                     |   |                           |   |
|-------------------------------------|---|---------------------------|---|
| a. Breathing or lung problems:..... | <input type="checkbox"/> Y <input type="checkbox"/> N | b. Heart trouble:.....    | <input type="checkbox"/> Y <input type="checkbox"/> N |
| c. Blood pressure:.....             | <input type="checkbox"/> Y <input type="checkbox"/> N | d. Seizures (fits): ..... | <input type="checkbox"/> Y <input type="checkbox"/> N |

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9):  Never used a respirator
- 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 to this questionnaire: .....  Y  N

**Part B.**

**Questions 10 to 15 below must be answered by every employee who has been selected to use either a fullfacepiece 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): .....  Y  N
11. Do you currently have any of the following vision problems?  
a. Wear contact lenses: .....  Y  N      b. Wear glasses: .....  Y  N  
c. Color blind:.....  Y  N      d. Any other eye or vision problems: .....  Y  N
12. Have you ever had any injury to your ears, including a broken ear drum:.....  Y  N
13. Do you currently have any of the following problems?  
a. Difficulty hearing:.....  Y  N      b. Wear a hearing aid:.....  Y  N  
c. Any other hearing or ear problem: .  Y  N
14. Have you ever had a back injury: .....  Y  N
15. Do you currently have any of the following musculoskeletal problems?  
a. Weakness in any of your arms, hands, legs or feet: .....  Y  N  
b. Back pain: .....  Y  N  
c. Difficulty fully moving your arms and legs:.....  Y  N  
d. Pain or stiffness when you lean forward or backward at the waist:.....  Y  N  
e. Difficulty fully moving your head up or down:.....  Y  N  
f. Difficulty fully moving your head side to side: .....  Y  N  
g. Difficulty bending at your knees: .....  Y  N  
h. Difficulty squatting to the ground: .....  Y  N  
i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs:.....  Y  N  
j. Any other muscle or skeletal problem that interferes with using a respirator:.....  Y  N

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewer's Signature

\_\_\_\_\_  
Date