



www.hsepartneringsolutions.com

RESPIRATOR MEDICAL EVALUATION FORM

For employees who are required by the company to wear some type of respirator. The employee is required to fill this out during work hours , they will keep the information secure until the pre-arranged date/time/location listed on the last page of this form or enclosed envelop. On that date they will bring this completed form to the medical provider so they can be examined to wear a respirator.

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 Full Name	
3. Your Age	
4. Your Sex	
5. Your Height	
6. Your Weight (lbs)	
7. Your Job Title:	
8. Phone to be called at if needed:	
9. Best time to call you	

10.

Has your employer told you how to contact the health care professional who will review this questionnaire	YES	NO
--	-----	----

11. Check the type of respirator(s) you will use (you can check more than one category):

N, R, or P rated disposable filtering facepiece aka dust mask with exhale port.	
Half face (mouth, nose) negative air cartridge respirator	
Full face (mouth, nose, eyes) negative air cartridge respirator	
Powered Air Purifying full face cartridge respirator (PAPR)	
Supplied airline full face respirator	
Self-Contained Breathing apparatus (SCBA)	

12.

Have you worn a respirator before ?	YES	NO
--	-----	----



RESPIRATOR MEDICAL EVALUATION FORM

If yes, please tell us which type of respirator you have used.	
--	--

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 (please check "yes" or "no").

1.

Do you <i>currently</i> 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:	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	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've been told about	YES	NO

4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?



RESPIRATOR MEDICAL EVALUATION FORM

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

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've been told about:	YES	NO

6. Have you *ever had* any of the following cardiovascular or heart symptoms?



RESPIRATOR MEDICAL EVALUATION FORM

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
d. 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
c. Blood pressure:	YES	NO
d. Seizures:	YES	NO

8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check off "N/A" 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
Not Applicable(N/A)		

9.

Would you like to talk to the health care professional who will review this questionnaire 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-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators,



RESPIRATOR MEDICAL EVALUATION FORM

answering these questions is voluntary.

10.

Have you <i>ever lost</i> 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 <i>ever had</i> 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 hearing aid:	YES	NO
c. Any other hearing problem:	YES	NO

14.

Have you <i>ever had</i> 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 moving your arms and legs:	YES	NO



RESPIRATOR MEDICAL EVALUATION FORM

d. Pain/stiffness when leaning forward/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 which interferes with using a respirator.	YES	NO

Part B Any of the following questions, and other questions that are not listed here may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

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're 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. Weakness in any of your arms, hands, legs, or feet:	YES	NO
b. Back Pain:	YES	NO
c. Difficulty moving your arms and legs:	YES	NO



RESPIRATOR MEDICAL EVALUATION FORM

d. Pain/stiffness when you lean forward/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
ii. Climbing a flight of stairs or a ladder carrying more than 25 lbs	YES	NO
j. Any other muscle or skeletal problem which interferes with using a respirator.	YES	NO
If you answered "yes," to any of these, describe these exposure(s):		

4.

List any second jobs or side businesses you have:	
---	--

5.

List your previous occupation(s) if different from work now:	
--	--

6.

List your current & previous hobby(s):	
--	--

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 medication(s) if you know them:		



RESPIRATOR MEDICAL EVALUATION FORM

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

a. HEPA Filtering facepieces/dustmasks with exhale ports:	YES	NO
b. Canisters (for example, gas masks) negative pressure:	YES	NO
c. Cartridges negative air:	YES	NO

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:

a. Escape only (no rescue):	YES	NO
b. Emergency rescue only:	YES	NO
c. Less than 5 hours <i>per week</i> :	YES	NO
d. Less than 2 hours <i>per day</i> :	YES	NO
e. 2 to 4 hours per day:	YES	NO
f. Over 4 hours per day:	YES	NO

12. Describe your work effort (only for the time period you are using the respirator(s)):

<p>a) Light (less than 200 kcal per hour)- indicate the estimated number of hours per shift: Examples of a light work effort are <i>sitting</i> while writing, typing, drafting, or performing light assembly work; or <i>standing</i> while operating a drill press (1-3 lbs.) or controlling machines.</p>	
<p>b) Moderate (200 to 350 kcal per hour): indicate the estimated number of hours per shift: Examples of moderate work effort are <i>sitting</i> while nailing or filing; <i>driving</i> a truck or bus in urban traffic; <i>standing</i> while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; <i>walking</i> on a level surface about 2 mph or down a 5-degree grade about 3 mph; or <i>pushing</i> a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.</p>	
<p>c) Heavy (above 350 kcal per hour): indicate the estimated number of hours per shift: Examples of heavy work are <i>lifting</i> a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; <i>shoveling</i>; <i>standing</i> while bricklaying or chipping castings; <i>walking</i> up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).</p>	

13.

Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator:	YES	NO
---	-----	----



RESPIRATOR MEDICAL EVALUATION FORM

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'll be doing while you're using your respirator(s):

--

17. Describe any special or hazardous conditions you might encounter when you're 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'll be exposed to when you're using your respirator(s):

Toxic Substance	TWA Exposure level (mg/m ³ or ppm)	Duration of Exposure (hrs/shift)	Comments, Peaks, etc...

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

--



RESPIRATOR MEDICAL EVALUATION FORM

Your Appointment for this respirator medical evaluation is scheduled as listed below. Note that the appointment is during work hours as you will be paid for the time you are at the appointment as if performing normal work. If you can't attend this appointment for some reason it is your responsibility to reschedule this to an acceptable time/day.

DATE	
TIME	
LOCATION	
PHONE	