Respiratory Medical Questionnaire

A.

Medical Evaluation Being Obtained For:

☐ Respirator Fit Testing

Employee/Student Name (First Name, Middle Initial Last Name)  Today's Date

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Birthdate</th>
<th>Race</th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Male  ☐ Female</td>
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</tbody>
</table>

Program:

B. To Be Completed by Employee/Student

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?
   □ Yes → Number years smoked: ___________  Amount you smoke: _______
   □ No → Month/Year you quit: ____________

2. Put a check in the boxes below if you have ever had any of the following conditions:
   □ Seizures (Epilepsy/Fits)
   □ Diabetes (Elevated blood sugar)
   □ Allergic reactions that interfere with breathing
   □ Claustrophobia (Fear of closed-in places)
   □ Trouble smelling odors

3. Put a check in the boxes below if you have ever had any of the following pulmonary or lung problems:
   □ Asbestosis
   □ Asthma
   □ Chronic bronchitis
   □ Emphysema
   □ Pneumonia
   □ Tuberculosis
   □ Silicosis
   □ Collapsed Lung
   □ Lung cancer
   □ Broken ribs
   □ Any other chest injuries or surgeries

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□ Any other lung problems that you've been told about (i.e. pleurisy)

4. Put a check in the boxes below if you currently have any of the following symptoms of pulmonary or lung illness:
   □ Shortness of breath
   □ Shortness of breath when walking fast on level ground or walking up a slight hill or incline
   □ Have to stop for breath when walking at your own pace on level ground
   □ Shortness of breath when washing or dressing yourself
   □ Shortness of breath that interferes with your job
   □ Coughing that produces phlegm (thick sputum or mucous)
   □ Coughing that wakes you early in the morning
   □ Coughing that occurs mostly when you are lying down
   □ Coughing up blood in the last month
   □ Wheezing
   □ Wheezing that interferes with your job
   □ Chest pain when you breathe deeply
   □ Any other symptoms that you think may be related to lung problems

5. Put a check in the boxes below if you have ever had any of the following cardiovascular or heart problems:
   □ Heart attack
   □ Stroke
   □ Angina
   □ Heart failure
   □ Swelling in your legs or feet not caused by walking
   □ Irregular heart rhythm
   □ High blood pressure
   □ Any other heart problem that you've been told about

6. Put a check in the boxes below if you currently take medication for any of the following problems:
   □ Breathing or lung problems
   □ Heart trouble
   □ Blood pressure
   □ Seizures (Epilepsy/Fits)

C. Additional Information Requested by the Licensed Health Care Professional

1. Are you taking medications for any reason? (Include those purchased over-the-counter.)
   □ No
   □ Yes

   Name of Medication  Reason Taking
   ___________________________  ___________________________
   ___________________________  ___________________________
   ___________________________  ___________________________
   ___________________________  ___________________________

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2. a. Have you ever worn a respirator?
   - No
   - Yes  What type ____________________________

   b. Have you experienced difficulty wearing a respirator?
   - No
   - Yes  Explain ____________________________

3. Have you had any illnesses, injuries, or medical problems since your last medical evaluation?
   - No
   - Yes  Explain ____________________________

4. Has your work ever been limited or restricted for medical reasons?
   - No
   - Yes  Explain ____________________________

5. Would you like to talk to a health care professional (who will review your questionnaire) about your answers?
   - No
   - Yes

I certify that my answers to this questionnaire are true, that I am physically and mentally able to perform all of the duties of my job, and that I know how to contact the Health Care Professional who will be reviewing this questionnaire. I understand that I may be required to see my physician for a medical examination and/or additional tests or procedures if I have “yes” answers to the questions in the questionnaire, or if I develop medical signs or symptoms related to my ability to use a respirator, or if my supervisor or the health care professional informs my employer that I need to be re-evaluated, or a change occurs in my workplace conditions that may affect my ability to wear a respirator.

Signature ____________________________  Date Signed ____________________________

References: