



Respirator Medical Evaluation Questionnaire

Please answer this questionnaire during normal working hours, or at a time and place that is convenient for you. To maintain confidentiality, please return this completed questionnaire in a sealed envelope or deliver it to the Hospital's Employee Health Service. This questionnaire will be reviewed by a licensed health care professional.

Please include a phone number where you can be reached by the health care professional who reviews the questionnaire:

Area Code: () _____ - _____

Indicate the best time to phone you at this number: _____ AM / PM

PLEASE PRINT:

Today's Date: Month: _____ Day: _____ Year: 20 ____

Your Name: (First) _____ (Last) _____

Job Title: _____ Dept./Division: _____

Shift: _____ Telephone Number / Extension: _____

Date of Birth ____/____/____ Age (to nearest year): _____

Sex: Male__ Female__ Height: _____ Weight: ____lbs.

If you are not sure of an answer below, you may leave it blank.

1. Check the type of respirator you will use (if applicable, you can check both "a" and "b"):

- 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).

2. Have you worn a respirator (check one): Yes__No__

If "yes", indicate what type(s): _____.

First Name: _____ Last Name: _____

Respiratory Medical Evaluation

DOB: ____/____/____

Questionnaire

Questions 1 through 9 must be answered by every employee who has been selected to use any type of respirator. 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 had any of the following conditions:

	YES	NO
a. Seizures (fits):		
b. Diabetes (sugar disease):		
c. Allergic reactions that interfere with your breathing:		
d. Claustrophobia (fear of closed-in places)		
e. Trouble smelling odors		

3. Have you ever had any of the following pulmonary or lung problems:

	YES	NO
a. Asbestosis:		
b. Asthma:		
c. Chronic Bronchitis		
d. Emphysema:		
e. Pneumonia:		
f. Tuberculosis		
g. Silicosis:		
h. Pneumothorax (collapsed lung):		
i. Lung Cancer:		
j. Broken ribs:		
k. Any chest injuries or surgeries:		
l. Any other lung problems that you've been told about		

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

	YES	NO
a. Shortness of breath:		
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline		
c. Shortness of breath when walking with other people at an ordinary pace on level ground:		
d. Have to stop for breath when walking at your own pace on level ground		
e. Shortness of breath when washing or dressing yourself:		
f. Shortness of breath that interferes with your job:		
g. Coughing that produces phlegm (thick sputum):		
h. Coughing that wakes you early in the morning:		
i. Coughing that occurs mostly when you are lying down:		
j. Coughing up blood in the last month:		
k. Wheezing:		
l. Wheezing that interferes with your job:		
m. Chest pain when you breathe deeply:		
n. Any other symptoms that you think may be related to lung problems		

First Name: _____ Last Name: _____

DOB: ___/___/___

Respiratory Medical Evaluation Questionnaire

5. Have you ever had any of the following cardiovascular or heart problems:

	YES	NO
a) Heart attack:		
b) Stroke:		
c) Angina:		
d) Heart Failure:		
e) Swelling in your legs or feet (not caused by walking):		
f) Heart Arrhythmia (heart beating irregularly):		
g) High Blood Pressure:		
h) Any other heart problem that you've been told about:		

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

	YES	NO
a) Frequent pain or tightness in your chest:		
b) Pain or tightness in your chest during physical activity:		
c) Pain or tightness in your chest that interferes with your job:		
d) In the past two years, have you noticed your heart skipping or missing a beat		
e) Heartburn or indigestion that is not related to eating:		
f) Any other symptoms that you think may be related to heart or circulation problems		

7. Do you currently take medication for any of the following:

	YES	NO
a) Breathing or lung problems:		
b) Heart trouble:		
c) Blood pressure:		
d) Seizures (fits):		

8. If you have never used a respirator, check the following space: _____,
and go to Question 9.

If you have used a respirator, have you ever had any of the following problems:

	YES	NO
a) Eye Irritation		
b) Skin allergies or rashes:		
c) Anxiety:		
d) General weakness or fatigue:		
e) Any other problem that interferes with your use of a respirator:		

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

YES	NO

Employee Signature: _____ Date: _____

Employee Health Service Reviewer Signature: _____ Date: _____



North Shore-Long Island Jewish Health System

Respirator Medical Evaluation Questionnaire

First Name: _____ Last Name: _____ DOB: ___/___/___

Dept/Div: _____ Title/Position: _____

This form outlines the results of the Occupational Safety and Health Administration (OSHA) Respirator Medical Evaluation. If you have any questions regarding this evaluation please call Employee Health Services.

Based on the review of the OSHA Respirator Medical Evaluation Questionnaire this individual is:

Medically approved to be fit tested for a respirator, with the exception of Full-Facepiece Respirators or Self Contained Breathing Apparatuses.

Not approved to be fit tested for a respirator at this time. Follow-up medical evaluation is needed.

Date: _____

Reviewer's Signature: _____

To Employee:

Please present this completed form to the Fit-Tester if you are approved to be fit tested