Respirator Medical Evaluation

The respirator medical evaluation is used to determine if an employee is physically able to use a respirator. Please fill out the medical questionnaire and bring with you to the medical evaluation.

Name:___________________________________

Department:______________________________

Manager/Supervisor:_________________________

Supplemental Information for Health Services for Respirator Wearers

This information must be provided to Health Services before the Dr. can make a recommendation for employee's ability to use a respirator.

1. Type of respirator to be used by the employee:

    Full Face   Half-face   Filtering facepiece

2. Frequency of use:

    1- 5 times per month

    10-20 times per month

    5-10 times a year

    1-5 times a year

    Emergency only

3. Duration worn:

    1-5 hours per use

    5-8 hours per use

    Less than an hour per use

4. The expected physical work effort:

    Light

    Moderate

    Heavy and intense

5. Additional protective clothing and equipment to be worn while wearing respirator:

    Tyvek suit   Apron   Safety goggles

    Goggles   Rubber gloves   Leather gloves

6. Temperature and humidity extremes that may be encountered:

    Indoor, air conditioned air

    Indoors, fresh air only

    Hot, humid temperatures

    Outdoors all types of temperatures, manholes

    All types of temperatures, inside or out, humidity extremes

7. Any other stress or condition that may have an effect on respirator wear:

MEDICAL QUESTIONNAIRE FOR RESPIRATOR USERS
Western Kentucky University
Environment Health & Safety

Once you have made your appointment for a pulmonary function test at WKU Health Services, you should print out and complete this questionnaire. Please bring it with you to your appointment, so the doctor can refer to it during your medical exam.

All respirator users must complete the questions in this section of the questionnaire.

Name:	Date:
Date of Birth:	Male/Female (circle one)
Height:	Weight:
Phone:	Job Title:
N, R or P disposable respirator?	Other type respirator?
I have / have not worn a respirator before.	Type:
Department number to bill for medical charges:	#

Do you smoke or have you smoked in the last month?	Yes	No
Have you ever had:		
Seizures?	Yes	No
Diabetes?	Yes	No
Allergic reactions that interfere with breathing?	Yes	No
Claustrophobia?	Yes	No
Trouble smelling odors?	Yes	No
Asbestosis?	Yes	No
Asthma?	Yes	No
Chronic Bronchitis?	Yes	No
Emphysema?	Yes	No
Pneumonia?	Yes	No
Tuberculosis?	Yes	No
Silicosis?	Yes	No
Pneumothorax (collapsed lung)?	Yes	No
Lung cancer?	Yes	No
Broken ribs?	Yes	No
Any chest injuries or surgeries?	Yes	No
Any other lung problems?	Yes	No

Do you currently have shortness of breath when:		
Walking fast on level ground or up a slight hill?	Yes	No
Walking at an ordinary pace on level ground?	Yes	No
When washing or dressing yourself?	Yes	No

That interferes with your job?	Yes	No
Do you currently have a cough that:		
Produces phlegm?	Yes	No
Wakes you up early in the morning?	Yes	No
Occurs when you are lying down?	Yes	No
Produces blood?	Yes	No
Do you currently have:		
Wheezing sensations?	Yes	No
Chest pain when you breathe deeply?	Yes	No
Symptoms that might be related to lung problems?	Yes	No

Have you ever had any of the following:		
Heart attack?	Yes	No
Stroke?	Yes	No
Angina?	Yes	No
Heart failure?	Yes	No
Swelling in legs or feet (not caused by walking)?	Yes	No
Heart arrhythmia?	Yes	No
High blood pressure?	Yes	No
Any other heart problems?	Yes	No

Have you ever had any of the following:		
Frequent pain or tightness in the chest?	Yes	No
Chest pain or tightness during physical activity?	Yes	No
Chest pain or tightness that interferes with your job?	Yes	No
Heart skipping or missing beats?	Yes	No
Heartburn or indigestions that is not related to eating?	Yes	No

Do you currently take medication for:		
Breathing or lung problems?	Yes	No
Heart trouble?	Yes	No
Blood pressure?	Yes	No
Seizures?	Yes	No

Answer this question only if you have previously used a respirator. If you have never used a respirator, go to the next section.

Have you ever had these problems while using a respirator?		
Eye irritation	Yes	No
Skin allergies or rashes	Yes	No
Anxiety	Yes	No
General weakness or fatigue	Yes	No

The following questions must be answered by employees who will be using a full-face piece respirator. Half face respirators or dust mask users are not required to answer.

Have you lost vision in either eye?	Yes	No
Do you wear contact lenses?	Yes	No
Do you wear glasses?	Yes	No
Are you color blind?	Yes	No
Do you have any other eye problems?	Yes	No

Have you ever had an ear injury (including a broken ear drum?	Yes	No
Do you have difficulty hearing?	Yes	No
Do you wear a hearing aid?	Yes	No
Do you have any hearing or ear problem?	Yes	No

Have you ever had a back injury?	Yes	No
Have you ever had:		
Weakness in your arms, hand, legs or feet?	Yes	No
Back pain?	Yes	No
Difficulty fully moving your arms & legs?	Yes	No
Pain or stiffness at the waist when moving?	Yes	No
Difficulty moving your head up or down?	Yes	No
Difficulty moving your head from side to side?	Yes	No
Difficulty bending your knees?	Yes	No
Difficulty squatting?	Yes	No
Difficulty climbing carrying more than 25 lbs?	Yes	No

Please bring this completed form with you when you see the doctor at your appointment. If you have any concerns about any of the questions, please let your doctor know.