RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

INSTRUCTIONS

EMPLOYEE:	Complete Part A and Part B, Section I. Submit this form directly to the Medical Provider.
MEDICAL PROVIDER:	Review the information provided by the employer (NOAA Form 57-17-01) and the employee (NOAA Form 57-17-02). Complete Part B, Section II of this form. Submit the completed questionnaire to MOC Health Services for distribution as needed.

PART A. SECTION I: EMPLOYEE INFORMATION

EMPLOYEE FULL NAME		DUTY STATION	
JOB TITLE		DEPARTMENT or BRANCH	DATE
AGE	GENDER ◯ Male ◯ Female	HEIGHT ft. in.	WEIGHT lb.
HOME or CELL PHONE NUMBER		WORK PHONE NUMBER	
Have you worn a respirator? (Question 8 is applicable) ◯ Yes ◯ No		IF "YES", LIST TYPE(S)	

PART A. SECTION II: RELEVANT MEDICAL HISTORY

Questions 1-9 are mandatory for all employees who have been selected to use any type of respirator. A follow-up medical examination is required for any employee who gives a positive response to any question among questions 1-8. Questions 10-15 are mandatory for employees who have been selected to use a full mask respirator or a self-contained breathing apparatus (SCBA). Questions 10-15 are voluntary for employees who have been selected to use only a half mask respirator.

1. **Do you currently 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 (fits) ◯ 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

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 have been told about ◯ Yes ◯ No

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

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

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 have been told about ◯ Yes ◯ No

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

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 two 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
f. Any other symptoms which 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 (fits) ◯ Yes ◯ No

If you have never used a respirator, check the following box and go to question 9. ◯

8. Have you ever had any of the following problems during or after the use of a respirator?

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

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

9. Would you like to talk to the health care professional who will review your responses to this questionnaire? ◯ Yes ◯ No

Questions 10-15 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, answering these questions is voluntary.

10. Have you ever lost 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 ever had 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 a hearing aid ◯ Yes ◯ No
c. Any other hearing or ear problem ◯ Yes ◯ No

14. Have you ever had 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 fully moving your arms and legs ◯ Yes ◯ No
d. Pain or stiffness when you lean forward or 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. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs ◯ Yes ◯ No
j. Any other muscle or skeletal problem that interferes with using a respirator ◯ Yes ◯ No

PART A. SECTION III: To the best of my knowledge, the information I have provided is true and accurate.

EMPLOYEE NAME

EMPLOYEE SIGNATURE	DATE

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

PART B. SECTION I: EMPLOYEE INFORMATION

EMPLOYEE FULL NAME	DUTY STATION

PART B. SECTION II: RESPIRATOR CLEARANCE RECOMMENDATION

- ○ The mandatory questionnaire has been reviewed and the employee has been found to be physically able to use the following respirators: (check all that apply)
  - ○ Half mask filter, negative pressure, air-purifying respirator
  - ○ Full mask filter, negative pressure, air-purifying respirator
  - ○ Full mask, positive pressure, self-contained breathing apparatus (SCBA)

  When wearing a respirator, the employee has been informed to limit activity level to the following (check one):

  - ○ Mild exertion (2-3 METS): negligible lifting, extended walking (flat surface), extended standing, writing
  - ○ Moderate exertion (4-5 METS): lifting 10 pounds (5 or more lifts per minute), pushing, pulling
  - ○ Heavy exertion (5-10 METS): life-saving activities, firefighting (no specified limitations)

  Other limitations when wearing a respirator (if any):

  _____

  _____

  _____

  This respirator clearance expires ○ 1, ○ 2, ○ 3, years from the date below.
  (Unless otherwise indicated, this respirator clearance will be valid for only one year.)

- ○ The employee has been found to be physically not able to use a respirator.
- ○ There is insufficient information to make a determination at this time.

  The following additional tests, or medical information, will be required in order to make a determination regarding the safe use of a respirator by this employee.

  _____

  _____

  _____

  _____

MEDICAL PROVIDER'S NAME (PRINT)	MEDICAL PROVIDER'S SIGNATURE	DATE
MEDICAL PROVIDER'S PLACE OF EMPLOYMENT		PHONE NUMBER

RESET