



Respiratory Protection Medical Surveillance Questionnaire

Part A. (Mandatory) Every employee who has been selected to use any type of respirator must provide the following information.

Section 1: Employee Identification

Name:		Home Phone:	
Date of Birth:		Work Phone:	
Social Security Number:		Gender:	
Job title:		Height (lbs.):	
Supervisor:		Weight (ft, in):	
Can you read English?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your employer told you to how to contact the healthcare professional who will review this?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Section 2: Current Respirator Use

Type of respirator you will use (you can select more than one).	<input type="checkbox"/> Filtering facepiece (N-95) <input type="checkbox"/> PAPR <input type="checkbox"/> Half facepiece <input type="checkbox"/> SCBA <input type="checkbox"/> Full facepiece <input type="checkbox"/> Supplied Air					
Have you worn a respirator in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, what type of respirator have you worn?	Brand		Model		Size	
Describe the job duties requiring the use of a respirator.						
Will there be physical exertion while wearing the respirator?	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Strenuous					
How long will you wear the respirator in a single day?	<input type="checkbox"/> Less than 4 hours/week <input type="checkbox"/> Less than 2 hours/day <input type="checkbox"/> 2-4 hours/day <input type="checkbox"/> Over 4 hours/day					
Is protective clothing also worn?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe the clothing:				
Identify hazardous or special work conditions	<input type="checkbox"/> Confined Spaces <input type="checkbox"/> Toxic Gases <input type="checkbox"/> Asbestos <input type="checkbox"/> Lead	Describe any other hazards:				



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Part B. (Mandatory) Every employee who has been selected to use any type of respirator must provide the following information.

Section 1: Personal Medical Information

If this is an initial examination, give answers based on your entire work history. If this is a periodic examination, give answers based on the past year. Please answer all questions fully.

Do you smoke tobacco? (No = less than 20 packs per life-time or less than 1 per day per year)		<input type="checkbox"/> Ever			
		<input type="checkbox"/> Within the Past Month			
		<input type="checkbox"/> Currently			
If yes, how many packs per day or pipes/cigars per week?	<input type="checkbox"/> ½ or less	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 2 or more	
If yes, how many years have you smoked?	<input type="checkbox"/> 1-9	<input type="checkbox"/> 10-19	<input type="checkbox"/> 20-29	<input type="checkbox"/> 30 or more	
Have you ever had any of the following conditions?	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bladder disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Allergic reactions that interfere with breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Claustrophobia Can't smell odors	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had any of the following pulmonary or lung problems?	Asbestosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Chronic bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Broken ribs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Chest injuries/surgeries	<input type="checkbox"/> Yes <input type="checkbox"/> No	Silicosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Collapsed lung	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Common Cold	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other lung problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you currently experience shortness of breath during any of the following activities?	Walking fast on level ground/up a slight incline	<input type="checkbox"/> Yes <input type="checkbox"/> No	Walking at your own pace	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Walking with other people at an ordinary pace on level ground	<input type="checkbox"/> Yes <input type="checkbox"/> No	Washing/dressing	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			Any other time that interferes with job	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you currently experience coughing?	That produces a phlegm (thick sputum)	<input type="checkbox"/> Yes <input type="checkbox"/> No	That occurs mostly when lying down	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	That wakes you early in the morning	<input type="checkbox"/> Yes <input type="checkbox"/> No	That produces blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you currently have any other symptoms of pulmonary or lung illness?	Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest pain when breathing deeply	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Wheezing that interferes with your job	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other related symptoms	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had any of the following cardiovascular or heart problems?	Heart attack.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Angina.	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Heart Failure.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart arrhythmia/irregular heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Swelling in your legs or feet (not caused by walking)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other heart problem.	<input type="checkbox"/> Yes <input type="checkbox"/> No	



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Have you ever had any of the following cardiovascular or heart symptoms?	Frequent pain or tightness in your chest.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Your heart skipping or missing a beat.	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Chest pain/tightness during physical activity.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heartburn not related to eating.	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Chest pain/tightness that interferes with the job.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other heart symptoms	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently take medication for any of the following problems?	Breathing/lung problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Heart trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently take medication for any of the following problems?	Breathing/lung problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	List any other medications you take now (including over-the-counter)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Heart trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If you have used a respirator in the past, have you ever had any of the following problems? (If you've never worn a respirator, proceed to the next question.)	<input type="checkbox"/> Eye Irritation			
	<input type="checkbox"/> Skin allergies or rashes			
	<input type="checkbox"/> General weakness or fatigue			
	<input type="checkbox"/> Anxiety			
	<input type="checkbox"/> Any other problem that interferes with your use of a respirator			

Would you like to talk to the healthcare professional who will review this questionnaire about your answers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Part C. (Supplemental) If you will be wearing a full facepiece or SCBA respirator, complete the following section. If not, please skip this section and sign at the bottom.				
Have you ever lost vision in either eye?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had an injury to ears/eardrums	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you currently have any of the following vision problems?	Wear contact lenses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Color blind	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Wear glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other eye or vision problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently have any of the following hearing problems?	Difficulty hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other hearing problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Wear a hearing aid	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you currently have any of the following musculoskeletal problems?	Weakness in arms, hands, legs, or feet.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty bending at knees.	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Difficulty fully moving arms and legs.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty squatting to the ground	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Pain/stiffness leaning forward/backward at waist.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty climbing stairs with > 25 lbs.	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Difficulty fully moving head up or down.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other muscle/skeletal problems that interferes with respirator use.	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Difficulty fully moving head side to side.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever had a back injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently have back pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

I hereby certify that the above information is true and accurate to the best of my knowledge.	
Employee's Signature	Date



RESPIRATORY PROTECTION Medical Clearance Form

This form is to be completed and signed by the physician or licensed healthcare professional who reviews the medical surveillance questionnaire. Indicate recommendations and any restrictions. This form must be completed, signed, and given to the Safety Officer prior to respirator fit-testing.

Employee Identification			
Name:		Division:	
Date of Birth:		Department/Facility:	
Date of medical evaluation:			

Recommendations (check one of the following):
<input type="checkbox"/> No restrictions on respirator use
<input type="checkbox"/> No respirator use permitted.
<input type="checkbox"/> Employee to use powered air purifying respirator (PAPR) only.
<input type="checkbox"/> No respirator use until further medical evaluation/diagnostic testing is complete.

Restrictions:
List any restrictions below (not for medical information or LOU sensitive material):

Based on the medical evaluation, this employee should be reevaluated on the following date:	
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Signature of Examining Physician or Healthcare Professional	Date