



HonorHealth.com

Respiratory Protection Medical Evaluation Questionnaire

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Other _____

Company Name	Supervisor/Manager	Phone ()	
Company Address	City	State	Zip
Employee Name		Employee Number	
Employee Address	City	State	Zip

This questionnaire will help in determining your ability to wear a particulate respirator/mask. All medical information is considered confidential. The following information must be provided by every employee who has been selected to use any type of respirator (please print).

Section I

- Today's date: _____
- Your age (to nearest year): _____
- Sex: Male Female
- Your height: _____ ft. _____ in.
- Your weight: _____ lbs.
- Your job title: _____
- A phone number where you can be reached by the health care professional who reviews this questionnaire: () _____
- The best time to phone you at this number: _____
- Has your employer told you how to contact the health care professional who will review this questionnaire? Yes No
- Check the type of respirator you will use (you can check more than one category):
 - N, R, or P disposable respirator (filter-mask, non-cartridge type only)
 - Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus)
- Have you worn a respirator: Yes No If yes, what type(s): _____

Section II

- Yes** **No** Do you currently smoke tobacco, or have you smoked tobacco in the last month?
- Have you **ever 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
- 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 problem 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

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 have 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 problems?

Yes **No**

- a. Breathing or lung problems
- b. Heart trouble
- c. Blood pressure
- d. Seizures (fits)

8. If you have used a respirator, have you ever had any of the following problems? If you have never used a respirator, check the following space and go to next question: Never used a respirator

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**
- a.

The questions below must be answered by every employee who has been selected to use either a full-face piece 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.

- Yes** **No**
10. Have you ever lost vision in either eye (temporarily or permanently)?
11. Do you currently have any of the following vision problems?
- Yes** **No**
- a. Wear contact lenses
 - b. Wear glasses
 - c. Color blind
 - d. Any other eye or vision problem
12. Have you ever had an injury to your ears, including a broken ear drum
13. Do you **currently have** any of the following hearing problems?
- Yes** **No**
- a. Difficulty hearing
 - b. Wear a hearing aid
 - c. Draining or painful ear
 - d. Ear infection
 - e. Any other hearing or ear problem
14. Have you ever had a back injury
15. Do you **currently have** any of the following musculoskeletal problems?
- Yes** **No**
- a. Weakness in any of your arms, hands, legs, or feet
 - b. Back pain
 - c. Difficulty fully moving your arms and legs
 - d. Pain or stiffness when you lean forward or backward at the waist
 - e. Difficulty fully moving your head up or down
 - f. Difficulty fully moving your head side to side
 - g. Difficulty bending at your knees
 - h. Difficulty squatting to the ground
 - i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.
 - j. Any other muscle or skeletal problem that interferes with using a respirator

Employee Name - Printed	Employee Signature	Date
Licensed Reviewer of Medical Evaluation Name - Printed	Licensed Reviewer of Medical Evaluation Signature	Date